

**IN THE COURT OF COMMON PLEAS
MONTGOMERY COUNTY, OHIO**

JACQUELYN MARES, M.D.	:	Case No. 2019 CV 02921
	:	
	:	
Plaintiff,	:	Judge E. Gerald Parker
	:	
v.	:	
	:	
MIAMI VALLEY HOSPITAL, et al.,	:	
	:	
Defendants.	:	

**PLAINTIFF’S MOTION TO CONTINUE DATE FOR RESPONSE TO
DEFENDANTS’ MIAMI VALLEY HOSPITAL, PREMIER HEALTH
PARTNERS, AND TERESA ZRYD, M.D. MOTION FOR SUMMARY
JUDGMENT (RULE 56(F))**

Pursuant to Ohio Civil Rule 56(F), Plaintiff, Jacquelyn Mares, M.D., hereby requests that the Court order a continuance to allow her to take discovery to establish facts necessary to respond to Defendants’ Miami Valley Hospital (“MVH”), Premier Health Partners (“PHP”), and Teresa Zryd, M.D. (“Dr. Zryd”) Motion for Summary Judgment. In support of this motion, Dr. Mares relies upon the accompanying memorandum of law and declaration of Marc D. Mezibov, attached hereto.

Respectfully submitted,

/s/ Marc D. Mezibov
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Attorneys for Plaintiff Jacquelyn Mares, M.D.

MEMORANDUM

MVH Defendants’ motion for summary judgment is premature and should be continued pending the completion of discovery, which has not yet been permitted or conducted in this case.

I. Legal Standard

This Court has not yet adopted any case management plan that permits the MVH Defendants to file a motion for summary judgment. Plaintiff Jacquelyn Mares, M.D. filed her Complaint in June 2019, and the MVH Defendants filed their Answer in July 2019. Under the local rules, this Court will now hold a pre-trial conference “to establish all filing and discovery deadlines” (Mont. Co. C.P.R. 2.01(B)(2)(b)(ii)), including “a discovery cut-off date” and “a date for the filing of . . . motions for summary judgment” (*id.*, 2.07(B)(2)(b) and (c)). The threshold step of adopting an orderly case management plan “will achieve the prompt and fair disposition of civil cases [and] provide the Court with an efficient means of controlling the flow of civil cases” (*id.*, 2.01(A)).

This Court’s local rules are consistent with the Ohio Rules of Civil Procedure. Rule 56(C) anticipates that discovery will precede any motion for summary judgment. Among other things, the specific categories of evidence admissible on such a motion include materials generated only in discovery (“pleadings, depositions, answers to interrogatories, written admissions, affidavits, transcripts of evidence, and written stipulations of fact,” emphasis added).

The precondition of discovery for summary judgment motions is well established in this District. *See, e.g., WAS, Inc. v. Alea London, Ltd.*, 2d Dist. Montgomery No. 20646, 161 Ohio App.3d 111, 2005-Ohio-2533, 829 N.E.2d 727, ¶ 8 (reversing summary judgment rooted in “speculation” because it was “premature until facts . . . are revealed”

in discovery); *Weinberg v. Weinberg*, 2d Dist. Montgomery No. 27834, 2018-Ohio-2862, 117 N.E.3d 907, ¶ 28 (reversing summary judgment rooted in a “relatively sparse” rather than “fully developed summary judgment record.”)

A continuance under Rule 56(F) is the proper relief where, as here, a motion for summary judgment relies only on “an ‘uncorroborated, self-serving affidavit [by defendant] . . . insufficient to establish the absence of any genuine issue of material fact where the opposing parties have not yet been afforded an opportunity to explore the underlying facts through discovery.” *Farmer v. PNC Bank, N.A.*, 2d Dist. Montgomery No. 27149, 2017-Ohio-4203, 92 N.E.2d 218, ¶ 11 (emphasis in original).

II. Disputed Issues of Fact

Discovery is likely to reveal evidence relevant to the following disputed issues of fact that is within the exclusive knowledge and control of the MVH Defendants and third parties. Because that evidence is not presently known, or accessible, to Dr. Mares or her counsel, they are unable to generate a full, accurate, and complete affidavit by Dr. Mares to oppose the MVH Defendants’ summary judgment motion and instead request this continuance under Rule 56(F). (Affidavit of Marc D. Mezibov (attached hereto as Exh. A)).

A. Reason for Dismissal

Dr. Mares alleges she was dismissed from her fourth year OBGYN residency position in order to pad the program’s accreditation statistics. Compl. ¶ 18. The MVH Defendants dispute this allegation of fact. MVH Answer ¶ 18. However, their motion for summary judgment does not address it at all, either by argument or evidence.

The MVH Defendants contend Dr. Mares was dismissed for irritability. Dr. Zryd Affid., ¶ 13. Dr. Mares disputes this allegation of fact. Compl. ¶ 19.

Dr. Mares also alleges that any irritability was a symptom of “physician burnout,” a workplace-related syndrome caused by Defendants. Compl. ¶ 20. The MVH Defendants dispute this allegation of fact. MVH Answer ¶ 18. However, their motion for summary judgment does not address it at all, either by argument or evidence.

B. Contract Obligations and Breaches

Dr. Mares alleges that the MVH Defendants had a contractual obligation, which they breached, to dismiss her only for specified reasons that did not include padding the program’s accreditation statistics. Compl. ¶ 20(a), (b), (c). The MVH Defendants’ dispute these factual allegations of obligation and breach. MVH Answer ¶ 20(a), (b), (c). Their summary judgment motion contains a long legal argument about contractual obligations, but in terms of evidence refers only to the employment agreement attached to Dr. Mares’s Complaint and Dr. Zryd’s personal, conclusory, and untested interpretation that Dr. Mares was an “at will” employee. Dr. Zryd Aff. ¶ 6.

Dr. Mares also alleges that the MVH Defendants had a contractual obligation, which they breached, to identify and ameliorate the burnout caused by their residency program’s working conditions, not contractual permission to dismiss her for its symptom of irritability. Compl. ¶ 22(e). The MVH Defendants’ dispute these factual allegations of obligation and breach. MVH Answer ¶ 22(e). But once again, as evidence their summary judgment motion cites only the employment agreement attached to Dr. Mares’s Complaint and Dr. Zryd’s personal, conclusory, and untested interpretation that Dr. Mares was an “at will” employee. Dr. Zryd Aff. ¶ 6.

Dr. Mares also alleges that the MVH Defendants had a contractual obligation, which they breached, to honor the findings of her due process panel and not to dismiss her when the panel found, as they did, there was no basis for dismissal. Compl. ¶ 22(e).

The MVH Defendants’ dispute these factual allegations of obligation and breach. MVH Answer ¶ 22(e). Their summary judgment motion presents evidence only in the form of Dr. Zryd’s affidavit, which simply reflects her belief that the employment agreement obligated the MVH Defendants to hold a due process hearing, but not to follow it, which of course is not “due process” at all. Dr. Zryd Aff. ¶¶ 10-13.

C. “Reasonable Minds” May Differ

The MVH Defendants’ motion for summary judgment repeatedly contends that “reasonable minds can only conclude” the disputed facts and law in their favor. Def. Mo., *passim*.

The problem for the MVH Defendants, however, is that nearly a dozen highly educated, impartial, and reasonable minds with first-hand knowledge of the facts have already differed with the MVH Defendants’ purported facts, interpretations and arguments. For example, far more faculty members of the OBGYN residency program opposed Dr. Mares dismissal than supported it, and eight of them wrote letters to the MVH Defendants expressing that support (attached hereto as Exh. B). Additionally, the full transcript of Dr. Mares’s “due process” hearing demonstrates the basis on which the panel’s three impartial faculty members sided with her (transcript attached hereto as Exh. C).

III. Conclusion

Discovery has not yet been permitted in this case, and Dr. Mares needs discovery in order to obtain evidence supporting her claims. The MVH Defendants’ motion for summary judgment is premature. Dr. Mares respectfully requests that it be continued pending the completion of discovery.

Respectfully submitted,

/s/ Marc D. Mezibov

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Attorneys for Plaintiff Jacquelyn Mares, M.D.

CERTIFICATE OF SERVICE

I hereby certify that on September 23, 2019, this document was eFiled via the Court's eFile system which shall send notifications of this filing to the following:

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Centerville, Ohio 45459

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/s/ Marc D. Mezibov

Marc D. Mezibov (OH No. 0019316)

**IN THE COURT OF COMMON PLEAS
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MIAMI VALLEY HOSPITAL, et al.,	:	
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Defendants.	:	

AFFIDAVIT OF MARC D. MEZIBOV

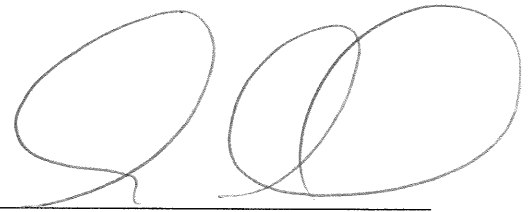
I, Marc D. Mezibov, having been duly cautioned and sworn, state as follows:

1. I am counsel for Plaintiff in the above-captioned matter.
2. On September 11, 2019, Defendants' Miami Valley Hospital, Premier Health Partners, and Teresa Zryd, M.D. filed a motion for summary judgment asking that Dr. Mares's complaint against them be dismissed.
3. To date, neither Dr. Mares nor any other defendant has conducted any discovery. In fact, no case management or pretrial order has yet to be established.
4. It has been my practice and experience that, prior to conducting any discovery, a pretrial conference be held to establish, among other things, dates for the exchange of information and a discovery cutoff date. To the best of my knowledge and belief, this process is established by this Court by Local Rule 2.07 governing pretrial procedures in civil cases.
5. It is my professional opinion that in order to fairly and responsibly respond to the motion for summary judgment filed by Defendants, it is essential that I be

permitted to conduct discovery, at a minimum, with respect to the following issues of fact:

- a. Whether Defendants complied with the terms and conditions of the employment agreement between Dr. Mares and Miami Valley Hospital;
- b. What are the nature, identity, and scope of the joint obligations and responsibilities of Wright State University and Miami Valley Hospital with respect to the operation of the Wright State University Obstetrics and Gynecology Residency Program;
- c. The nature and quality of Dr. Zryd's assessment of the recommendations of the individual defendants that Dr. Mares be dismissed from the Residency Program;
- d. What were the nature, frequency, and substance of any communications pertaining to Dr. Mares by and between Dr. Zryd and any of the individual defendants;
- e. Whether Dr. Mares's termination was motivated, in whole or in part, by Defendants' consideration of her physician burnout;
- f. Whether Defendants complied with their contractual obligations to mitigate the effects of Dr. Mares's physician burnout;
- g. Whether Dr. Mares's termination was motivated in whole or in part by consideration of the program's need to maintain its accreditation.
- h. Whether Dr. Mares was treated similarly to other residents by the individual defendants with respect to her continued participation in the Residency Program;

Further Affiant Sayeth Naught.

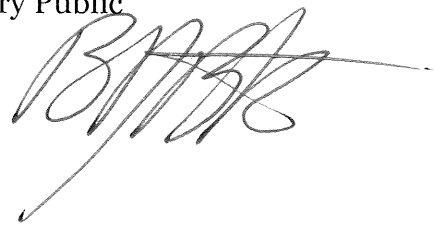


Marc D. Mezibov

Sworn to and subscribed before me this 13 day of September, 2019:



BRIAN J. BUTLER
Attorney At Law
Notary Public, State of Ohio
My commission has no expiration date
Sec. 147.03 R.C.





One Wyoming St.
Dayton, Ohio 45409
mvh.org

To: Dr. Susan Edwards, Ph.D.
Executive Vice President for Academic Affairs and Provost

From: Dr. Marc Belcastro, D.O.
Chief Medical Officer and Vice President of Operations
Premier Health, South Region
mrbelcastro@premierhealth.com
937-208-2712
937-974-9314

Dear Dr. Edwards,

I am writing on behalf of Dr. Jackie Mares, the OB/Gyn resident that was recently released from her program with about 6 months remaining. While I am not intimately familiar with the specifics of her case, I have reviewed her appeal letter and have picked up a few themes. Her leaders and mentors often expressed disapproval of her decisions with silence or lack of clear and direct feedback. There seemed to be no attempt to coach her through situations where she felt unsafe or how to regain the trust of a patient. She appropriately apologized for one situation and had developed some degree self-awareness and self-reflection. Finally, a finding of untruthful documentation was added to the list of complaints to which she had no recollection or time to adequately respond.

Prior to the hearing and decision, I had been informed of her situation in general terms from the maternal fetal medicine physicians providing her support. This is a group that spends a significant amount of time teaching the residents, so her character would not be foreign to them. They reached out to me because of my considerable experience in coaching and mentoring physicians and nurses in relationship building, listening and communication skills, as well as emotional awareness. These are skills I have learned and used through Premier Health's engagement with a company out of Columbus called, "Business of People". I currently facilitate a physician/advance practitioner cohort. I expressed a willingness to meet with Dr. Mares up to weekly if necessary, for the remainder of her residency to ensure her success.

As a Chief Medical Officer, I understand the importance of our Bylaws, Rules and Regulations, and holding our providers accountable for professionalism and behavior. Healthcare is a sacred responsibility and patients deserve our best. I also believe that leaders must be very clear and direct about expectations when someone's life and career hang in the balance. Finally, as leaders, we need to extend grace and design a clear plan for improvement to help every individual be successful if possible. Dr. Mares was given only time, and her leaders acted after a number of events transpired, but I do not believe she was provided with the feedback, expectations, or resources to be as successful as I know she can be. This is a life, and leaders need to value and care for those they lead. I ask that you strongly consider a different path for Dr. Mare to complete her residency with clear guardrails.

Please feel free to contact me,

Sincerely,

Marc Belcastro, D.O.

A handwritten signature in black ink, appearing to read "Marc Belcastro", written over a light blue circular stamp.



The Center For Maternal-Fetal Medicine,
Ultrasound and Genetics
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December 14, 2018

Susan Edwards, PhD
Executive VP for Academic Affairs & Provost
University Hall 256
3640 Colonel Glenn Hwy.
Dayton, Ohio 45435-0001

Re: Jacquelyn Mares, MD

Dear Dr. Edwards:

This letter is written on behalf of Dr. Jacqueline Mares. I am privileged to serve as her advisor during the appeal process addressing her termination from the Wright State University Boonshoft School of Medicine, Obstetrics and Gynecology Residency Program. To introduce myself, I am a product of this residency program, class of 2007. In my years here I have worked with over 110 residents in the WSU BSOM OB/GYN Program. In my honest opinion, Jackie is as human as the rest of us. She is young and under pressure, burned out and trying to cope with the immense stressors of our amazing profession. She is also competent, compassionate, skilled, hard-working, and dedicated to patient care. Jackie possesses immense potential.

Prior to her termination, Jackie and I had developed a solid working and interpersonal relationship. In my time as her formal advisor, she has confided in me a raw, detailed account of OB/GYN residency as viewed through her lens. Through my subsequent, objective investigations, I have come to understand that she has not committed a single grievance I have not witnessed before in this program. Some of her grievances I myself was guilty of in training, and others I have seen committed by attending physicians who are currently recommending her termination from this training program. My recognition that she has become a casualty of this dichotomy between expectations and reality is, quite frankly, one of the most sobering realizations in my experience as an attending physician to date.

I am openly fraught by worry for Jackie Mares and her future. She has dedicated her *entire* adult life to becoming a physician. Her identity has been permanently altered by the art and practice of medicine. She has suffered from burnout during the rigors of residency training, and despite moments of desperation she has developed a reinvigorated passion for obstetrics and gynecology. Jackie has pushed ahead with good work ethic and determination to develop a skill set that illustrates competency and great potential for future growth. I along with an overwhelming cohort of physicians and other medical personnel at Miami Valley Hospital are distressed by her termination because we have come to understand we *need her and what she brings to our profession*.

The collection of documents and letters presented to you is a representative portion of the narrative of the WSU BSOM OB/GYN Residency Program as experienced by one Dr. Jacqueline Mares. It is in part an historical account of the program's strengths and successes, as well as its struggles and shortcomings. Jackie's story also carries a cautionary message comparable to that of the canary in the coal mine. My exploration and dissection of her residency experience has manifested as my realization that the canary metaphor has evolved into real human experience within the WSU OB/GYN Residency Program. During her appeal hearing, Dr. Yaklic acknowledged that we failed Jackie. Yet here we are, bearing witness to an abominable sacrifice of the proverbial lamb.

As a physician educator, I ardently believe we must re-center our focus to the observation made by the program's chair. Furthermore, we should explore our failure in resident education lest we risk recurring future loss of physicians of great potential. As stewards of physicians in training, we must commit ourselves not only to the promotion of their academic success and technical skills, but also to fostering their emotional and mental well-being.

Dr. Edwards, please examine the transcript of the appeal hearing and all materials Jackie provided to Dr. Painter during that time. Study the details of the appeal committee's recommendations and action plan. Read each letter of support word-by-word. Consider what appears to be a breach of due process by Dean Margaret Dunn when she cited a patient safety report (PSR) as justification for overturning the appeal committee's recommendations although this PSR was never presented to the committee, and as a result Jackie was not able to address it prior to Dean's decision. I implore you to do the difficult but right thing by reinstating and supporting Dr. Jacqueline Mares as a PGY-4 in the WSU BSOM OB/GYN Residency Program.

You are very welcome to contact me if you wish to discuss this matter in person or by phone (cell: 937-477-7178; asst: 499-0122). Thank you for attention.

Sincerely,

A handwritten signature in black ink, appearing to read "Melanie M. Glover". The signature is fluid and cursive, with a large loop at the end.

Melanie M. Glover, MD
mmglover@premierhealth.com
Chair, MVH Department of OB/GYN
Chair, MVH Safety Committee
Chair, Morbidity and Mortality Improvement
Clinical Assistant Professor, Dept. of OBG, BSOM, WSU



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December 12, 2018

Susan Edwards Ph.D.

Provost

Wright State University

Dear Dr. Edwards,

I am writing in support of Dr. Jacqueline Mares' appeal to complete her residency in the Department of Obstetrics and Gynecology Boonshoft School of Medicine located at Miami Valley Hospital. I have trained her for over 2 years. The details behind her dismissal and inability to complete her 4th and final year of residency will no doubt be readily available to you. However, I support that she should be allowed to complete her residency.

I am the Women's Health Clerkship Director and an Associate Professor in the WSU-BSOM Department of Ob-Gyn. I manage 3rd year medical student education in a didactic fashion and by providing a good clinical learning environment. Dr. Mares is one of our preceptors, as are all the residents in our program. She was identified in several student evaluations to be a preceptor who provided a hostile working environment. This was through communication mistakes and poorly demonstrated attitudes toward student education. Because of multiple negative evaluations, the BSOM administration insisted on management. The Dept. Ob-Gyn Chair, Dr. Jerome Yaklic and Residency Director, Dr. Michael Galloway, responded by counseling of Dr. Mares and initiating her probation.

Dr. Mares made the changes that were asked of her and this was reflected in medical student evaluations that indicated a positive change. There were no negative evaluations of her in the 6 months subsequent to her probation. In addition, there were some commendations of her teaching. I was very pleased to see this change.

The decision that the Dept. Ob-Gyn made to not allow Dr. Mares to complete her residency was based on her negative communications with individuals on several levels including: subordinates, colleagues, attending physicians, and most recently a patient's family member. This collection of events over the last two years indicate that she has a problem with the management of her own stress leading to unprofessional communication.

As a member of the WSU Dept of Ob-Gyn Residency Education Committee, I originally voted that she be allowed to finish her residency despite repetitive infractions of professionalism because I weighed this communication problem against her ability to be an Ob-Gyn. Her knowledge and skills in my specialty are on par with her peers and she has demonstrated excellent communication skills. Her communication mistakes are inconsistent and unpredictable. It seems to be that during extreme stress, Dr. Mares' attention to this weakness



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breaks down. Still her mistakes are not excusable and she needs dedicated help to have consistent and dependable good communication skills.

With all due respect to my Chair, Dr. Yaklic, my Dean, Dr. Dunn and Assistant Dean, Dr. Painter, and others who spent hours poring over this problem of how to handle Dr. Mares and her communication blunders, and made the decision that she is appealing now, I still stand by my feeling that she should be allowed to complete her residency. With the right help and with time she will manage her stress and she will consistently communicate effectively. I ask that you give her this chance.

Most sincerely,

A handwritten signature in black ink that reads "Sheela Barhan". The signature is fluid and cursive, with the first name "Sheela" and last name "Barhan" clearly distinguishable.

Sheela Barhan M.D.

Associate Professor

Clerkship Director of Women's Health

WSU- Boonshoft School of Medicine

Sheela.barhan@wright.edu

Cell# 937-219-5741



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December 13, 2018

Susan Edwards, PhD
Executive VP for Academic Affairs & Provost
University Hall 256
3640 Colonel Glenn Hwy.
Dayton, Ohio 45435-0001

Re: Jacquelyn Mares, MD

Dear Dr. Edwards:

I request you please read this letter carefully. You have an opportunity to right a wrong which is contrary to the University's core values, save a young physician's career, and prevent irreparable harm to Wright State University.

I am writing this letter on behalf of Jacquelyn Mares, MD, whom Dean Margaret Dunn has recommended be terminated from the WSU BSOM Obstetrics and Gynecology Program. My affiliation with this residency program began 1992, and I believe my judgement and experience are sound when I unequivocally say the Dean has made a grave mistake.

I am a member of the Department's Clinical Competency Committee and was present when the original recommendation was made on 10/3/18 to terminate Dr. Mares' employment. In retrospect, it is clear the information presented to this committee regarding Dr. Mares' conduct was hearsay, biased, and flawed. In truth she suffers from burnout, and despite this mental health condition has significantly improved her professionalism during her probationary period.

Per the University's due process, Dr. Mares' case was reviewed on 11/7/18 by a formal review panel. Comprised of three BSOM faculty, the panel's evaluation of the evidence took six hours. After hearing all sides, the panel recommended she continue on probation, and added elements to treat burnout, improve her professionalism, and succeed as a physician. These elements include professional counseling, a formal course on professionalism, oversight, and mentoring.

This recommendation was subsequently rejected by the Dean who cited two additional brand new allegations, neither of which Dr. Mares was ever made aware, nor given the opportunity to explain. As a faculty member, attending physician at Miami Valley Hospital, and member of the Clinical Competency Committee, I never heard about the new allegations. The Dean's action was capricious and arbitrary, and ignored the due process and work of three physicians who dedicated the better part of a day developing a solution to help Dr. Mares.

The crux of the issues with Dr. Mares relate to lapses in professional behavior, which she acknowledges and has objectively improved. She has never placed patients in danger, nor has her clinical care been an issue. She recognizes that she responds to stress unfavorably, and has been working on her reactions. Who among us does not have room to improve their response to stress?

The University and Medical School have an obligation to provide Dr. Mares the opportunity to be successful. The review panel's plan does just that. Termination will ruin her career. She will never be able to practice medicine. It will also damage the reputation of the Department of Obstetrics and Gynecology, the BSOM, and Wright State University. Residents, medical students, and medical school applicants will know that the program chooses to terminate residents rather than provide the resources needed to combat mental health conditions such as physician burnout. The damage to our reputation will have long lasting negative effects, something Wright State can hardly afford.

I hope from this appeal you clearly see Dr. Mares' termination is wrong, and that she is deserving of our program's help. I have tried to be brief, and I would be happy to discuss any of this content further with you in person, or you may call me on my cell phone, 937-478-9556. Thank you for your attention to this matter.

Sincerely,

A handwritten signature in black ink, appearing to read "David S. McKenna", followed by a long horizontal flourish line.

David S. McKenna, MD
Clinical Associate Professor



One Wyoming St.
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(937) 208 8000
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December 11, 2018

Susan Edwards, PhD
Executive VP for Academic Affairs & Provost
University Hall 256
3640 Colonel Glenn Hwy.
Dayton, Ohio 45435-0001

Re: Jacquelyn Mares, MD

Dear Dr. Edwards:

I am writing in support of Dr. Mares to continue in our OB/GYN residency program.

I am volunteer faculty and have worked with Dr. Mares on many occasions and have never witnessed performance or behavior that would warrant dismissing her. I also do attending call two to four times a month which has allowed me to work closely with her.

I have noted that at times she has seemed aloof and/or depressed. I am not sure what definitive action has been taken to help her. I serve on the Physician Effectiveness Committee at Miami Valley Hospital. When we identify a problem with a physician, there is a process by which that individual is referred for professional help and monitored. It is specific and defined, not recommended, not just a mentor, etc. That is what we do for a staff member, I would hope we could do as much or better with a resident we have committed to train.

I have asked around about this matter. Nurse managers, nurses, fellow residents, none of who supports her dismissal. My experience is when we truly have a bad egg, the good riddance sentiments are unanimous.

I suggest we implement a defined action plan to help this resident we committed to train. This is a person who has worked hard her whole life to get to this point. She will not be able to find an R4 position somewhere else. We need to be sure with have exhausted every effort. I'm not sure we have.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Scott Bemby", written over a horizontal line.

J. Scott Bemby, MD



Miami Valley Hospital
Premier Health Partners

The Center For Maternal-Fetal Medicine,
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12 December, 2018

Susan Edwards, PhD
Executive VP for Academic Affairs & Provost
University Hall 256
3640 Colonel Glenn Hwy.
Dayton, Ohio 45435-0001

Re: Jacquelyn Mares, MD

Dear Provost Edwards:

I write this letter in strong support of Dr. Jacqueline Mares, to appeal for her reinstatement as a chief resident to complete her training. I would like this document to be submitted as a testament to her character, knowledge, and clinical skills as a provider of obstetrical care. I have personally known and worked with Jackie since she began her residency at Wright State University Department of OB/GYN in July, 2016. During this time I have been a witness to her exceptional knowledge base and growing personal/professional skills. I have seen her develop from a reserved new resident joining an already established class of interns just beginning their second year into a capable and intuitive physician who has integrated seamlessly into her class while continuing to evolve and grow in the difficult environment of an OB/GYN residency. She has a unique combination of natural intelligence combined with humility, empathy, kindness, and the quest for knowledge in order to provide her patients with the most accurate and appropriate care for their situations.

Jackie has always stood out to me; not just in her class of five residents, but in my fifteen years of teaching residents from multiple medical schools and in different hospitals throughout the U.S. She is clearly well-read, as she has a broad and impressive knowledge base. Whether I am rounding on the antepartum service, staffing the high risk obstetrical service, or giving a lecture - Dr. Mares often knows the answers to my questions or already has an evidence-based plan of care in place for her patients. Due to her solid fund of knowledge, she frequently has thoughtful questions about areas of controversy; the 'grey zones'. Together we have looked up the answers to questions that she raises. This curiosity serves her well when it comes to coming up with thoughtful solutions to clinical questions where there is no clear answer.

During her first year in our program, Dr. Mares and I took care of a very ill and difficult patient. 'Ms. Doe' had a long history of substance abuse and was being cared for in the inpatient setting for complications stemming from intravenous drug use. I witnessed Jackie take ownership of Ms. Doe and treat her with amazing kindness and empathy (and also her dry sense of humor). Several more patients with similar stories ensued, which inspired Dr. Mares to put together a case series

on these patients and to initiate a relationship with an attending cardiologist who co-managed them. The three of us worked together to put a paper together which Jackie submitted for publication.

In all of my encounters with Dr. Mares, she has exhibited a commitment to her patients and a desire to practice medicine which is current and evidence-based. I have known her to challenge information that she comes across; I have always seen this as an effort on her part to understand what the situation at hand is, and to ensure that the assessment and plan being executed for a patient is the correct one. I find this to be an essential character for physicians - the continued pursuit of knowledge in the endeavor of patient care.

In summary, Dr. Jacqueline Mares is an intelligent, caring, and competent OB/GYN resident who has exhibited strength, courage, and growth in the more than two years that I have known her. I am struck by her combination of natural intelligence, curiosity, hard work, humility, and kindness towards her patients and co-workers. I am more than happy to discuss her qualifications at any time and I strongly support her reinstatement into the residency program in order to allow her to complete her training.

Sincerely,



Samantha Wiegand, MD,
Clinical Assistant Professor, Dept. of OBG, BSOM, WSU
slwiegand@premierhealth.com



The Center For Maternal-Fetal Medicine,
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One Wyoming St.
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December 12, 2018

Susan Edwards, PhD
Executive VP for Academic Affairs & Provost
University Hall 256
3640 Colonel Glenn Hwy.
Dayton, Ohio 45435-0001

Re: Jacquelyn Mares, MD

Dear Dr. Edwards:

I have had the pleasure of working with Dr. Mares as an attending physician on the Maternal Fetal Medicine Service since her arrival at Miami Valley Hospital as a second-year resident. I find her to be a very competent, compassionate, and intelligent physician. I strongly support her appeal to be reinstated as a fourth-year resident in Obstetrics and Gynecology at Wright State University.

I am well aware of the events surrounding her firing and the events that led up to it, both from personal communications with Dr. Mares and communications with persons who were involved in her defense. I had the opportunity to review the transcripts from her hearing held in front of a three-person panel, which took place on November 7, 2018.

I think that the circumstances of Dr. Mares need to be reviewed very carefully. I am certain that you now do have in your possession all the pertinent documents. There are a number of problems that are easily extracted from the evidence available. However, there are two issues that are especially egregious.

First, in my view, the judgement that was passed by Dr. Dunn to overturn the recommendation of the panel is not supportable by the available facts. If there are other facts that support her firing but were not made available to Dr. Mares and the three-person panel at the time of the hearing, then the rules of due process were grievously breached.

Second, when you review the course of events that are pertinent to this case, you will find that there were some failings on the part of Dr. Mares. However, she did show evidence of continued improvement and was functioning at a level, which was appropriate to her level of training. Firing Dr. Mares on October 4, 2018, in her fourth year of residency and essentially only two months after she was told by her program director on August 29, 2018 that she was doing well

and would be off her probation by the end of the year, is unforgivable. The only circumstance that I can imagine doing this is if Dr. Mares presented danger to her patients. There is no evidence of this being the case. Even if such evidence exists, the fact that it was not shared with Dr. Mares prior to her firing is equally unforgivable.

In summary, from the available evidence of which I am aware, the due process has failed Dr. Mares and she should be reinstated. Purely from the human standpoint, it is hard to fathom how these decisions could have been made by a "compassionate" group of people.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Sonek', with a stylized flourish at the end.

Jiri D. Sonek, MD, RDMS

Medical Director, Maternal Fetal Medicine, Ultrasound, and Genetics Center

Clinical Professor, Wright State University Boonshoft School of Medicine



Miami Valley Hospital
Premier Health Partners

The Center For Maternal-Fetal Medicine,
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December 11, 2018

Susan Edwards, PhD
Executive VP for Academic Affairs & Provost
University Hall 256
3640 Colonel Glenn Hwy.
Dayton, Ohio 45435-0001

Re: Jacquelyn Mares, MD

Dear Dr. Edwards:

I am writing in support of Dr. Jackie Mares' appeal to you, for reversal of the Dean's decision to reject the recommendations of the review panel. You truly have the opportunity to change the course of an individual's life in a very positive fashion.

I realize that you have been inundated with numerous documents discussing Dr. Mares' tenure as an OB/GYN resident. As a member of the review panel, I was afforded greater than 10 hours for intense evaluation of this material. One compelling topic which was discussed at length during the panel's briefing was the issue of burnout. Unless you have had the opportunity to review the transcript of the panel's hearing, you might not see much documentation of this subject.

Almost all of Dr. Mares' dysfunctional behaviors that warranted the disciplinary actions are components of the diagnostic criteria for resident burnout. This was never considered by the residency director, clinical competency committee, or department chairman as a probable explanation for Dr. Mares' numerous problems. For this reason, appropriate steps to best help this resident were never implemented. This was attested to by the Department Chair, during the review, when Dr. Yaklic admitted, "We failed Jackie."

Dr. Mares fully acknowledged that her behaviors and communication skills were unprofessional and needed serious attention. She was never given any formal guidance in how she could improve in these areas. Nevertheless, on her own, she was able to significantly improve the scores of her medical student evaluations. This objectively supports her readiness and ability to make change. She was and she remains teachable.

From the accompanying letters of support from both faculty and Jackie's peers, it's apparent I'm not alone in my assessment of the young physician's value to our department and women's healthcare in general. It is my humble opinion that the system has truly failed this individual.

The recommendations of the review panel are not "an easy row to hoe" for Dr. Mares. Clinically, she is exceptionally competent. Her patients receive excellent care. There is little risk to the University and Department of OB/GYN to allow her to finish her residency. She has a group of dedicated faculty and peers to support her in meeting all the goals set before her.

Thank you for your time and consideration of this individual's future. Please free feel to contact me if you have any additional questions regarding Dr. Mares.

Sincerely,

A handwritten signature in black ink, appearing to read 'C. Croom', written over the word 'Sincerely,'.

Christopher S. Croom, MD
Chairman, Ethics Committee, Miami Valley Hospital
Clinical Assistant Professor, WSU, Dept. of OBG
Cell: 416-4565

DUE PROCESS HEARING

* * *

In re: Dr. Jackie Mares

TRANSCRIPT OF PROCEEDINGS

* * *

DATE OF HEARING: Wednesday, November 7th, 2018

PLACE OF HEARING: Miami Valley Hospital

* * *

ATTENDEES:

Albert Painter, Psy.D
Melanie Glover, M.D.
Jackie Mares, M.D.
Ted Talbot, M.D.
Jerry Yaklic, M.D.
Lisa Boydston
Stacey Poznanski, D.O.
Linda Barney, M.D.
Christopher Croom, M.D.

* * *

EXHIBIT C

1 DR. PAINTER: Dr. Talbot will begin
2 by presenting the program's reasons for
3 termination. Dr. Yaklic is here as the chair
4 supporting that and also presenting information
5 and -- and data.

6 During this proceeding, the panel may
7 ask anyone anything at any time, okay? So if you
8 could -- if there's a question, we'll have -- Dr.
9 Talbot's presenting about any of the information,
10 you may ask him. The same thing with Dr. Yaklic.

11 During Dr. Mares' presentation of her
12 reasons for appeal, the same thing, you may ask
13 her any questions that you may have.

14 And, of course, Dr. Mares, you can
15 ask Dr. Talbot and Dr. Yaklic anything as well.

16 So does anyone have any questions?
17 What we will do after both parties have presented
18 and you all have exhausted the questions that you
19 have about the information that's been presented,
20 I will dismiss everyone except the three of you.

21 In the past, we have a chance here to
22 discuss the information, discuss your thoughts
23 about it, your opinions about it and we'll try to
24 come with a conclusion.

25 It does not have to be unanimous.

1 Two of three will constitute a quorum in that
2 respect.

3 I also want to make it clear that
4 what you -- your task here is not only to gather
5 information and draw a conclusion, but to make a
6 recommendation to two people, and those two people
7 are Dr. Dunn, who is the school of medicine dean,
8 and in this case, Mr. Maiberger, who is the CEO of
9 Miami Valley Hospital that's delegated his role in
10 making a decision about that recommendation to Dr.
11 Zryd, who is the chief academic officer for
12 Premier Health, and is very familiar with -- as
13 all of you know, very familiar with residency
14 functioning having been a resident program
15 director for, I think, fourteen years.

16 So we felt like she would, as an
17 executive for Premier and for the hospital, fill
18 that role more appropriately, if you would.

19 So before we begin, does anyone have
20 any questions? I'll be glad to do the best I can
21 to answer. Do you need anything else from us
22 before we start?

23 THE COURT REPORTER: No, just make
24 sure everybody keeps their voice up.

25 Speak up. All right. I will --

1 without any questions -- and if you have questions
2 as we move through this, please just bring them up
3 and I'll do my best to answer them.

4 So, Dr. Talbot, I'm going to turn the
5 floor over to you.

6 DR. TALBOT: Okay. Thank you. I
7 will skip a lot of the introductions, but just to
8 mention that I have been the program director
9 since July of this year filling in for Dr.
10 Galloway who has been program director for eight
11 years.

12 I was his associate program director
13 from 2014 until I took this program director
14 position, and also from 2016 until 2018, I was the
15 chair of our clinical competency committee which
16 advises the program director.

17 So once I became the program
18 director, I could no longer serve on the clinical
19 competency committee.

20 I have been a fully affiliated
21 faculty member since March of 2012, and I have had
22 privileges here at Miami Valley Hospital and been
23 a clinical faculty member dating back to 2007, so
24 I have worked with residents quite a bit.

25 Dr. Mares joined our program as a

1 transfer in as a second year resident, and this is
2 documented in her resident file. She came from a
3 program in Long Island.

4 If you could pull up 30 -- page 37
5 and 36 of her resident file and put it up there.
6 By May of 2017, there was concerns from the
7 rotations at Wright-Patterson Air Force Base and
8 Miami Valley Hospital to warrant a letter of
9 warning from Dr. Galloway as recommended by the
10 CCC.

11 Areas of concern were patient care,
12 practice based learning, interpersonal
13 communication and professionalism.

14 And on the bottom of that if you go
15 down to you will need to show, he at that time
16 said you will need to show significant improvement
17 in the core competencies listed above.

18 In the next paragraph it says you
19 risk not advancing past your current level of
20 repeating this year or being dismissed from the
21 residency program. And Dr. Mares signed it.

22 The next -- so that obviously did not
23 happen or we would not be here today. So in June
24 of 2007, there is an incident I will just briefly
25 touch base on with Dr. Mares refusing to see a

1 preterm patient -- preterm pregnant patient who
2 was having vaginal bleeding.

3 And doctor -- her chief had asked her
4 to evaluate the patient and she said -- instead
5 told the nurse to evaluate the patient.

6 The patient ultimately delivered and
7 Dr. Mares did not want to be any part of that
8 delivery. So Dr. Galloway attempted to talk with
9 her, but she did not talk with him and left.

10 Then they later talked in the
11 afternoon and he recommended a five day mandatory
12 leave of absence. In addition, he had urged her
13 at the letter of warning meeting and this meeting
14 to seek evaluation from a physician to assist her
15 if there were physical or mental health concerns
16 affecting her ability to perform as a resident, in
17 other words, fit for duty.

18 She was provided a phone number for
19 Premier Health employee assistance program
20 offered -- offering confidential assistance to
21 employees and conflict management and other
22 work-related problems.

23 Then in November of 2017, doctor --
24 this is on page 25 in that. Dr. Galloway and Dr.
25 Barhan, our student clerkship coordinator, had met

1 with Dr. Brenda Roman and Dr. Painter regarding
2 unprofessional interactions with medical students.

3 It says there were several comments
4 that related to abuse of medical students by
5 residents related to verbal and unethical
6 behavior. Dr. Jacqueline Mares was one of the
7 residents mentioned in the comments and -- section
8 of the evaluation.

9 Dr. Mares was formally notified of
10 this results and it's unacceptable performance of
11 professionalism related to medical student
12 interactions.

13 I would like to fast forward to a six
14 month evaluation that they had in January where
15 Dr. Galloway mentioned -- met with Dr. Mares and
16 they discussed that the main concern with Dr.
17 Mares was her self-knowledge, lack of confidence
18 and the lack of desire to pursue clinical practice
19 after residency, and that she was offered again
20 and declined access to counseling or professional
21 counseling at the time, but was aware that it was
22 available.

23 In March of 2008 (sic), March 8th,
24 that is page 13 and 14 in the -- on the -- in her
25 file, she was formally placed on probation by Dr.

1 Galloway.

2 There were three main reasons for the
3 probation, which I would like to discuss. The
4 first was concerns related by faculty from
5 Wright-Patterson Air Force Base and that -- about
6 a lack of participation in the operating room,
7 concerns about poor attitude interfering with
8 patient care, and one example was cited at morning
9 rounds, instead of a formal checkout of each
10 patient, she said everyone is doing fine, and
11 handed the list to her colleague and left.

12 The second concern that placed her on
13 probation was an incomplete research project that
14 she had with less than two months from her
15 resident research day.

16 Dr. Galloway and Dr. Maxwell sent her
17 an e-mail of these concerns, this was on page 18
18 in the file, saying that there was little data and
19 little recruitment and little time to complete
20 it.

21 Dr. Maxwell asked me if I was willing
22 to allow her to present preliminary data that we
23 had on a study relating to barriers to prenatal
24 care, and I -- this is an example, I think, where
25 I more than advocated for her, so I helped her

1 out.

2 We let her present the data and meet
3 her minimum necessary requirements for research
4 data.

5 Dr. Maxwell has tried to continue the
6 project with her with little success, and
7 ultimately over the summer took her off the
8 project. I'm not pushing it further because I
9 still feel she meets the minimum requirements for
10 the research component to graduate.

11 But the most important reason for the
12 probation was the continued poor evaluations and
13 remarks by medical students that continued from
14 the January to June, 2008 -- '18 segment.

15 And I -- this is what you guys have,
16 and I want to go to the second page where -- the
17 very top one that says, Jackie -- it's Jackie
18 Mares, we don't have a Meyers in our program.
19 Very disrespectful in front of patients and
20 interns -- or to intern during delivery to the
21 point where she overtook the delivery and did a
22 vacuum extraction without gloving, gowning or
23 washing her hands to prove a point.

24 She yelled at the intern the entire
25 time, even when Dr. Galloway is in the room. She

1 disrespected the attending in the situation as
2 well saying that she was in charge and his
3 opinions were inferior to hers.

4 Another one halfway down the page
5 says Dr. Jackie Mayers (sic) was utterly
6 disrespectful to students, attendings, nurses and
7 other co-residents on multiple occasions.

8 Oftentimes when I was assigned to
9 high risk, there was a senior for the team. She
10 would not let me work with her. Further, she was
11 disrespectful to her senior resident on the team
12 at the time, Tony. She was swearing at him at one
13 point over something ridiculous.

14 She was also rude to nurses, had an
15 attitude. Acted like they were dumb. And then at
16 one point, I was trying to help her by starting a
17 history and physical note for her as she had asked
18 me to.

19 Then I was called to a delivery, thus
20 I pended the note. When I returned, she had
21 complained about me to one of her seniors. Made
22 it seem like I hadn't done what I was supposed
23 to.

24 She later told me that I ruined her
25 entire note. I was embarrassed to be around her.

1 And finally, Dr. Mares was very
2 unprofessional. She disregarded attendings'
3 instructions sometimes and was rude to them.

4 She blatantly told Dr. Croom that she
5 did not read and wasn't planning on it when he
6 asked her what she had been reading and learning
7 about.

8 She told me that I took a patient
9 that was too complicated for me and did not even
10 give me a chance to try to follow them. She just
11 wanted me to follow patients that were simple.

12 There are many more -- several more,
13 but these are the most salient ones.

14 So it became clear with me taking
15 over the program director position in the summer,
16 that I had talked to Dr. Yaklic and that I would
17 be meeting with her periodically as required on
18 probation.

19 And our first meeting was April 20th.
20 That is on pages 11 and 12 in her resident file.
21 And basically at the -- on the April meeting I
22 told Jackie that I was starting over with her.
23 This was a new fresh perspective. I was giving
24 her a clean slate and I wanted to start from the
25 beginning with what we -- I mean by

1 professionalism.

2 And so I talked to -- I meant
3 treating others with respect and honesty, a
4 diligent work ethic and attempting, when at all
5 possible, to not outwardly vocalize frustrations
6 to the extent that they become common that could
7 deceive as -- be perceived as hurtful to others;
8 expressions of anger, frustration, et cetera.

9 Then we had informal meetings in
10 the -- over the summer months. In July, I
11 remember in the lounge off labor and delivery she
12 discussed with me her intention that we wanted to
13 do a missions trip to Africa, I believe, and being
14 in a remote site, she would have to be off of
15 probation and what did she need to do and when
16 could she be off probation.

17 And we had talked about late in this
18 calendar year, and that the main issue holding her
19 back was professionalism.

20 And I even remember relaying an
21 instance where I used an example of a resident I
22 worked with that would get pages in the middle of
23 the night, wake up, rant off ten, 12 expletives
24 and then calmly answer the phone. This is Dr.
25 Paley answering a page, and we chuckled at that.

1 And basically whatever somebody needs
2 to do to vent and then not have it carry into
3 their interactions.

4 And then Dr. Yaklic and I, in August,
5 were called by the medical school to answer to
6 some of these comments that were in the first half
7 of the year, as there is sometimes a lag, and we
8 more than went to bat for her.

9 We had discussed that we felt maybe
10 Dr. Galloway didn't emphasize it enough, that we
11 really did, and that fortunately from the student
12 clerkship, I was able to get a batch of
13 evaluations from July of this year that showed
14 that she involved students within the OR and did
15 some teaching, and so we advocated for her.

16 And I relayed that to her at her
17 August 29th meeting with me, which I thought was
18 an overly positive meeting, but then,
19 unfortunately, the wheels come off from here.

20 And I have several e-mails and
21 examples coming in these last few pages of your
22 little packet that I gave you.

23 The first instance was just two days
24 later after our meeting, I was made aware by Dr.
25 Madison of an incident where the OB service was

1 consulted on a patient with -- a pregnant patient
2 with a appendi -- or not appendicitis, pancreatis,
3 and Dr. Mares called into the operating room to
4 discuss with their chief resident, and she was
5 extremely rude to the nurse that took the phone
6 call, the chief resident and the attending, and
7 they brought it to Dr. Madison, our faculty's
8 attention.

9 And Dr. Madison confronted her about
10 the situation and reported Jackie responded that
11 she knew she had exploded and her behavior was out
12 of line and stated that she apologized to the
13 chief resident and took herself off the patient's
14 care team.

15 And while that might seem appropriate
16 in this situation, this has become a theme when
17 relations go south is that Dr. Mares excuses
18 herself from the teamwork care of the patient.

19 So this behavior was deemed
20 inappropriate, and Dr. Madison told her that if
21 she had unresolved concerns regarding patient
22 management, that the AO is a good impartial third
23 party.

24 The next incident is in the presence
25 of Dr. Yaklic on morning report. We -- the night

1 team was managing a psychiatric patient that
2 likely had psychosis, and had a mother that also
3 had violent tendencies, but it was deemed that the
4 patient would need a C-section because she wasn't
5 progressing in labor.

6 And in -- with morning report, five
7 or ten minutes into it, the full team of
8 residents, students, nurses, Dr. Mares -- and this
9 verbiage may not be exactly, but this is what I
10 was told, that she used profanity directed at the
11 medical illness using an adjective before the word
12 crazy, and that adjective described the guano of a
13 flying male. I am not touching her. You all can
14 do the C-section, I'm going to clinic.

15 And so Dr. Yaklic, I think -- I don't
16 want to speak for him, but wanted damage control,
17 he decided not to escalate the confrontation and
18 said, well, if you have other things to do, we
19 will take care of this patient, and he did the
20 C-section with a different resident.

21 And then lastly an incident I was
22 involved with as well as another faculty member,
23 Dr. Kindig, and she wrote to me, and so that is
24 also in your packet at -- let me find it. The
25 page I believe is page five.

1 On September 23rd, I came on call to
2 relieve you at seven a.m. You are aware of the
3 case that was handed over to me that day. The
4 patient was 38 weeks pregnant and came to the
5 hospital with severe left-sided pain.

6 She had been observed in another
7 hospital in Lima and discharged, but she continued
8 to have pain, and so came to Miami Valley for a
9 second opinion.

10 I was told on report that there were
11 some personality issues with our chief resident,
12 Dr. Mares, and the patient's mother, a nurse from
13 Lima.

14 With my involvement the night before,
15 I can tell you the personality issues or clash
16 were related to Dr. Mares had strongly advocated
17 that the patient was acceptable for discharge.

18 The patient's mother and the father
19 of the baby were not comfortable with that. It
20 started to escalate, and so I came and evaluated
21 the patient and felt that we did not have enough
22 information to feel comfortable discharging the
23 patient, so she was kept overnight.

24 Back to Dr. Kindig's account then, it
25 says I was told in morning report that the patient

1 had slept through the night and was -- pain was
2 improved so she was planned to be discharged, but
3 that was not the scenario.

4 Upon examination, she was very
5 uncomfortable, enough that I could not palpate her
6 abdomen on the left side. I left the room and
7 called the chief resident, Dr. Mares, asking her
8 to come see the patient with me and bring the
9 ultrasound machine to evaluate.

10 She declined by refusing and stated
11 she was not going to have any more encounters with
12 this patient. I suggested her mother was not here
13 and she told me to call the third year, who did
14 come.

15 They saw and evaluated the patient,
16 and after discussing options, they decided to do a
17 Cesarean.

18 Dr. Mares stated that she would not
19 be part of the Cesarean section. At the time of
20 the Cesarean section, they found a small abruption
21 on the (inaudible) globe on the side of her pain
22 and an abnormal cord.

23 Dr. Kindig discussed these findings
24 with the team. Dr. Mares did not respond.
25 Ultimately the patient and family were happy with

1 her outcome, but they did state that the intern
2 and Dr. Kindig were the only ones who evaluated
3 the patient by doing an examination, that Dr.
4 Mares did not touch the patient, just argued that
5 she needed to be discharged.

6 Dr. Kindig wrote my evaluations of
7 Dr. Mares have continually shown her attitude and
8 professionalism are inappropriate. I am unable to
9 talk with her in person about her actions as she
10 becomes defensive and I am not her direct
11 supervisor.

12 She also had concerns because Dr.
13 Mares has verbalized to many people on occasion
14 that she does not plan to practice med -- OB-GYN
15 after residency, and that she had asked her that
16 in order -- if she wants to pursue a job in the
17 insurance industry, that she would need to be
18 taken care of -- or she would need to do clinical
19 medicine first.

20 Dr. Mares stated she would not be
21 taking care of patients in the future. Dr. Kindig
22 felt that this was a safety issue as well as one
23 of professionalism. If she is not the OB-GYN
24 physician taking full responsibility for the care
25 of that patient, then she believed that this was a

1 risk to patient safety, and should there not be a
2 backup provider, she feels for serious injury or
3 death under her watch.

4 This matter also escalated to the
5 point that the patient's mother and family
6 registered a formal complaint against -- no
7 residents in general, but primarily the senior
8 resident, related to this interaction.

9 And when I found out more from the
10 complaint, there were two things that stuck out.
11 Dr. Mares and the patient's mother, it was -- it
12 was escalating, and that -- there is some accounts
13 from the nurse that the mother was treating Dr.
14 Mares unfairly, but then she made some
15 inflammatory comments.

16 One was that all women late in
17 pregnancy are miserable, but we don't admit them
18 for that. And, two, that should they elect to
19 stay, they would have to pay thirteen thousand
20 dollars per night.

21 And so Dr. Belcastro was concerned
22 basically how we're counseling patients and the
23 discussion of the patients.

24 So I had verified those statements
25 with the nurse that took care of her that day. I

1 have since talked to all of the residents that
2 were involved, and I did try to talk to Dr. Mares
3 about it as well as did Dr. Yaklic and didn't get
4 anywhere.

5 So my -- let me -- I'm trying to come
6 to a conclusion here, that these incidents were
7 discussed at the CCC meeting on October the 3rd,
8 and this is presented in her file, and the
9 concerns were professionalism, communication,
10 patient care interaction, overall performance.

11 They reviewed evaluations and
12 numerous recent incidents, discussed at length and
13 posed serious concern for her overall progress
14 through the probationary status.

15 Much debate was centered on the fact
16 that she had verbalized she does not want to
17 continue to practice OB-GYN, like we discussed,
18 and they raised concern by attendings that she is
19 going through the motions to graduation and
20 presents a patient safety issue.

21 The two instances of her refusal to
22 care for a surgical patient with Dr. Yaklic and
23 Dr. Kindig were discussed, and a formal movement
24 was made to remove Dr. Mares from the residency
25 program. It was seconded. The official vote from

1 the CCC was six to two in favor of removal.

2 So the following day I met and had
3 several conversations. I had conversations with
4 Dr. Croom, her advisor, Dr. -- both Dr. McKenna
5 and Croom had been advising her.

6 I had discussions with Dr. Yaklic. I
7 discussed with Dr. Mares. I had her come in, and
8 I asked her about those two specific incidents.

9 Her answers to me was, with the one,
10 the patient had a knife, and that was why she
11 couldn't be any part of that psychiatric patient.

12 And then the two, on the patient that
13 was admitted where she had advocated for
14 discharge, she said, well, you changed the plan,
15 it's your -- the attendings had changed the plan.

16 And I thought, well, that answer
17 doesn't hold a lot of water with me because
18 residents are involved all the time with faculty
19 where the plan may be changed and they continue to
20 involve their care.

21 I really think probably the root of
22 the problem was the soured physician/patient
23 relationship with that patient and her mother,
24 that when it escalated and ongoing care was
25 needed, that was why Dr. Mares excused herself.

1 So with all of those, I decided to
2 proceed with enacting the recommendations of the
3 CCC for dismissal.

4 So just to summarize, there are
5 deficiencies in professionalism, communication,
6 interpersonal skills to the extent that they
7 affect patient care and show a persistent and
8 pervasive lack of respect for all of the
9 following: The profession of medicine, medical
10 students, resident colleagues, faculty attendings
11 in and outside of our department, nurses and even
12 patients.

13 Her behavior is inconsistent and
14 unpredictable. It can be highly unprofessional,
15 and thus far, it has been proven to be unfixable.

16 I fear the continuation in our
17 program towards graduation that these instances
18 will continue. In other words, past behavior is a
19 predictor of future behavior.

20 Why the CCC, I believe -- and this is
21 why the CCC had such concerns to vote six to two
22 in favor of dismissal from our program, including
23 members who had previously been strong supporters
24 of her earlier in her training, such as the former
25 program director.

1 My decision was very difficult in
2 light of many things. One, I am just three months
3 into my tenure, and this is the last thing I
4 wanted to have to do out of the gate.

5 Two, we are short handed in that we
6 had a chief transfer to family medicine and we
7 have one that is on maternity leave, so we are
8 currently at half our complement, but I cannot
9 allow those reasons to affect this decision, and
10 ultimately I have to defend the integrity of our
11 resident program. I cannot turn a blind eye.

12 This is why I wore the white coat
13 this morning, was that I do respect this
14 institution, our medical students, our residents,
15 my chair, our faculty, both on and off the CCC,
16 and all of our sites, and I feel that I am acting
17 in the best interests of the residency program.

18 I cannot allow this behavior to not
19 only tarnish the learning environment, but to be
20 perceived by others in our department that it is
21 acceptable on my part, whether it be junior
22 residents, nurses, patients or faculty physicians.

23 I do need the support of all of my
24 faculty at all the sites, and I am also concerned
25 with going forward and may have to justify to the

1 RRC of the ACGME in our self-study when we talk
2 about our CCC and what recommendations we view and
3 how does the program director respond, that if I
4 had disregarded these strong recommendations, that
5 I would not be doing our program, hence, myself,
6 any good.

7 So with that, I -- that is the basis
8 for my decision, and that's all I have for now.

9 DR. PAINTER: Questions for Dr.
10 Talbot at this point?

11 DR. CROOM: Ted, three sort of --
12 I'll use the term the sentinel cases, that's not
13 an appropriate term, but the cases that you cited;
14 did Dr. Mares have the opportunity to explain her
15 side of the story to you prior to those cases
16 being presented to the CCC?

17 DR. TALBOT: I did not talk to her
18 about them prior to the CCC. The biggest thing
19 was the -- the last case where I talked about the
20 patient had needed a C-section that Dr. Kindig was
21 on.

22 Dr. Kindig had talked to her. My
23 main concern before -- even before the CCC --
24 because I was not made aware of this
25 patient-lodged complaint and going to Dr.

1 Belcastro until the night before the CCC, the
2 e-mails are the night before.

3 And so that morning I tried to talk
4 with all three residents involved. I did not see
5 Dr. Mares. Now, maybe I missed her. The
6 attending sheet may show, but I talked to the
7 other two residents involved, and mainly used it
8 as a learning experience.

9 I -- as far as the -- the -- but my
10 concern with her mainly was that she recused
11 herself of taking care of this patient ongoing.

12 When Dr. Kindig -- it wasn't the
13 problem that I changed plan or even that I
14 advocated for admitting, because it wasn't a clear
15 diagnosis at the time, there was some gray zones,
16 and the patient's mother was being overly
17 difficult.

18 So my concern was that in this kind
19 of situation, you don't just say I'm out, you
20 know, somebody else is going to have to deal with
21 this, and so I felt that Dr. Kindig had addressed
22 that.

23 I felt Dr. Madison had addressed
24 another incident. In hindsight, you know, you can
25 always put this as a learning experience, I could

1 always do better. I probably will going forward
2 try to talk with every single event I can with the
3 resident as soon as I'm aware of it happening, but
4 that was not the case this time.

5 DR. CROOM: Well, as her mentor and
6 someone who would want to help her in these
7 situations, you know, neither myself or Dr.
8 McKenna were notified of any of these. You know,
9 Dr. McKenna found out at the CCC.

10 DR. YAKLIC: I think Ted's point is
11 that these events all occurred very closely in
12 time to the CCC meeting. I think the other piece
13 of it is --

14 DR. CROOM: Well, some of us --

15 DR. YAKLIC: Each of them
16 individually probably would not have risen to the
17 point of a recommendation for dismissal.

18 The problem and the challenges six
19 months into probation for unprofessional behavior
20 at a time when Ted is hoping the CCC is going to
21 say, when you see some improvement, let's take her
22 off of probation; you're at the end of -- you're
23 halfway through your chief year almost and we need
24 to say that you've made progress.

25 We have not one, not two, but three

1 incidents that all occur within very short order
2 prior to the meeting showing that -- really that
3 the progress we thought we were making perhaps was
4 not as positive as we had -- we seen and that
5 actually it really just showed the same pattern of
6 behavior that had been going on both prior to
7 probation and during probation.

8 So it's -- you know, I wish that
9 morning in my report I would have said something,
10 but, again, it was like kind of shock, and you're
11 going, okay, well, let's just downplay it, not a
12 big deal.

13 It wasn't the event itself. Again,
14 if you have a patient you can't deal with, clearly
15 you should recuse yourself from them, but you
16 don't do in that way in front of medical students,
17 your -- your junior residents and your -- and your
18 nursing staff, right? You do it on the side
19 professionally.

20 And that's the unpredictability and
21 the unprofessional outbursts that create these
22 difficulties.

23 CCC includes representatives from
24 nursing who continually complained about these
25 issues and their ongoing nature.

1 I mean, I think Ted did everything in
2 his power to try to advocate on her behalf, but at
3 the end of the day, the data continued to show
4 problems during that probation period and at a
5 time where -- I mean, were Jackie a second year,
6 it might be a different story, right? We could
7 maybe talk about it. We have time to see if this
8 is going to improve.

9 This is a chief resident who's had
10 ongoing problems since her second year, has been
11 warned, has been put on probation, and has still
12 failed to make adequate progress.

13 I personally believe part of that is
14 because she has a lack of commitment to the field.
15 Whether you want to practice medicine or not is
16 irrelevant when it comes to finishing this
17 program, but if you're not committed to your
18 specialty, you're not committed to change
19 necessary to perform that obligation, and I think
20 that's unfortunately the situation.

21 I think Mike did what he could do to
22 try to remediate this, the short time he was
23 program director and as an associate program
24 director and as director or CCC for many years
25 there.

1 It's -- I think it's an unfortunate
2 situation here as well.

3 DR. CROOM: Well, I think it's my
4 concern you had a letter basically saying that she
5 was doing well in all areas, and then you said the
6 wheels fell off.

7 Now, somebody who's on probation for
8 what's a serious concern, every incident is
9 important.

10 DR. TALBOT: Right.

11 DR. CROOM: I mean, to sit back and
12 collect incidents -- I mean, to help someone, who
13 is -- my experience is you don't know what you
14 don't know, and if her behavior is inappropriate
15 and it's not addressed at the moment, particularly
16 with the people who have been sort of told,
17 you're -- even your mentors, I just -- I'm a
18 little -- when you say it was short order that the
19 CCC met in October, these things were in August
20 and September. You had plenty of time in my mind
21 to have allowed us to address it.

22 DR. TALBOT: I think part of the
23 frustration, not only with myself, but with other
24 faculty is that when we approached Jackie and they
25 had this issue at the base and they've had -- our

1 faculty has had it, that normally a person would
2 say, oh, yes, I'm sorry, whatever, what do I need
3 to do to get better?

4 Jackie would -- would like go into a
5 shell and she wouldn't talk about it and she would
6 say I need a leave of absence or give you a short
7 answer.

8 It just wasn't -- it wasn't -- I felt
9 like if you're really vested, you know, you really
10 want to graduate, show me what do I need to do,
11 how do I do it? Do I need another resident coming
12 in every time I see a patient? Do I need an
13 attending? Does the hospital need a coach? There
14 was none of that. That was never suggested.

15 DR. CROOM: That was the value of a
16 mentor. Mentors are --

17 DR. TALBOT: But it still happened.

18 (Thereupon, the court reporter
19 interrupted the proceedings.)

20 DR. CROOM: A mentor is someone that
21 establishes that safe relationship, and I can tell
22 you it took some work to establish that, but it
23 was established, and, you know, to deny the mentor
24 the opportunity to discuss that case when there
25 was plenty of time to do it, it -- you know, I

1 just wanted to make that point.

2 DR. YAKLIC: I will also say though,
3 Dave was her former mentor. The two of you
4 started working together and she gravitated
5 more --

6 DR. CROOM: But Dave was never
7 notified of this case.

8 DR. YAKLIC: -- she gravitated more
9 towards you, and that was allowed by the
10 department because we felt that that personal
11 relationship was important, but Dave was involved
12 in that process as well. Dave sits on our CCC.
13 Dave was a vote --

14 DR. CROOM: But he wasn't notified of
15 these cases.

16 DR. YAKLIC: Dave was a vote to
17 dismiss, and in recent discussions, has continued
18 to hold that opinion. I know you guys have had
19 discussions. You can agree to disagree, but there
20 was mentor input through that process.

21 DR. CROOM: He wasn't aware of those
22 three cases. Prospectively, Terry, he didn't
23 get -- he did not get --

24 DR. YAKLIC: It didn't change his --
25 (Thereupon, the court reporter

1 interrupted the proceedings.)

2 DR. CROOM: I just said that Dr.
3 McKenna was not prospectively informed of these
4 cases. He found out about them the day the CCC
5 met. Not an appropriate time for a mentor to
6 discuss the case.

7 DR. YAKLIC: And his point at the CCC
8 was not let me sit down as her mentor and
9 re-discuss these. It was a vote towards
10 termination.

11 He didn't feel that additional
12 discussion -- and I don't want to speak for Dave,
13 okay? But Dave had the opportunity at that
14 meeting to sit there and say, I believe we need to
15 go back and talk to Jackie, I believe we need to
16 do more.

17 He felt that he could make a decision
18 at that point and his decision was to terminate
19 her.

20 And I -- like I said, I don't want to
21 speak for Dave, okay? But -- but his vote, I
22 think, speaks for itself.

23 DR. TALBOT: And I don't know how
24 often she was --

25 DR. CROOM: And then what it was was

1 it a secret ballot --

2 DR. TALBOT: No.

3 DR. YAKLIC: No.

4 DR. CROOM: -- is what they told me,
5 so I don't know.

6 DR. TALBOT: No, it wasn't.

7 DR. CROOM: Okay. So he -- all
8 right.

9 DR. TALBOT: I don't know that he was
10 still meeting with Jackie regularly. He did say
11 at the CCC that he had wished that you could have
12 been there, but you were out of town, but in that
13 same instance, in that e-mail from Dr. --

14 DR. CROOM: Well, I wasn't out of
15 town.

16 DR. TALBOT: You weren't? I don't
17 know.

18 DR. CROOM: No, I wasn't.

19 DR. TALBOT: But he just said he
20 wished you could be there, but in that same
21 instance where she -- that Dr. Kindig relays that
22 she had said that that morning, Dr. Mares was
23 arguing with Dr. McKenna about management of a
24 high risk patient.

25 So I don't know. Maybe that -- that

1 relationship had soured. I don't -- all I know is
2 that he -- when he has talked to me, he has said
3 the bad Jackie can be pretty bad, and I think
4 that's his concern, what ultimately led to his
5 vote.

6 I wasn't going to get into who voted
7 which way on the committee, other than to say that
8 those that had prior -- previously supported her
9 strongly no longer did.

10 DR. BARNEY: Did the resident avail
11 herself of any of the opportunities for
12 professional help over -- since --

13 DR. YAKLIC: Not that we're aware of.

14 DR. TALBOT: No.

15 DR. POZNANSKI: Was it ever mandated?

16 DR. TALBOT: It was not mandated, and
17 actually I don't think it can be mandated. I --

18 DR. POZNANSKI: I didn't think so.

19 DR. TALBOT: Yeah.

20 DR. PAINTER: You can do a fitness
21 for duty, which is a different --

22 DR. BARNEY: Right.

23 DR. POZNANSKI: Was that -- can that
24 be mandated?

25 DR. TALBOT: It can be strongly

1 encouraged, which it was back in the letter of
2 warning --

3 DR. YAKLIC: Strongly encouraged.

4 DR. POZNANSKI: But not required.

5 DR. TALBOT: -- it would have been on
6 the probation.

7 (Thereupon, the court reporter
8 interrupted the proceedings.)

9 DR. TALBOT: I had mentioned
10 that over the summer just -- not in saying you
11 should do this in the summer. Do you feel like
12 you're having issues with professional anxiety?
13 (Inaudible).

14 I don't think it's that. I think
15 it's more a personality and a difficulty
16 controlling anger with frustration or something
17 that doesn't go as she is anticipating.

18 DR. POZNANSKI: I have a -- kind of a
19 side question. If a resident does not take their
20 Boards after completion of the program, how does
21 that affect perception of the program or numbers?

22 I know if they don't pass, obviously
23 that's reflected. If they don't take the Boards.

24 DR. TALBOT: The ACGME just requires
25 that of our graduating residents, 80 percent have

1 to take the Boards, and of those that take it, 80
2 percent have to pass. If you do not have that,
3 you get a citation. So -- and that's when they
4 graduate.

5 So somebody could be -- and the
6 reason I would say 80 percent is somebody could be
7 out on maternity leave or something else and not
8 take it for six months or whatever and then the
9 program won't get penalized, but obviously we
10 encourage all of our residents to take it.

11 And if we -- you know, if we have
12 six, we can have one and still meet the 80
13 percent. If we have less than that, not
14 necessarily.

15 DR. POZNANSKI: Right. I mean, it
16 just -- it begs the -- the question comes to mind
17 that with her indicating her lack of desire to go
18 into clinical work and potentially not even taking
19 the Boards, how that affects the program and
20 whether that plays into a decision to terminate.

21 DR. YAKLIC: It -- it clearly can
22 have a negative impact on the program.

23 DR. POZNANSKI: Sure.

24 DR. YAKLIC: I don't think it plays
25 directly into the decision to terminate. I think

1 if that were the only incident, clearly we would
2 not have terminated Jackie. Desire to practice
3 your chosen specialty is not something we can
4 necessarily mandate, I mean, once you enter the
5 program. We -- as Ted mentioned, one of her
6 classmates left and went into family medicine, you
7 know.

8 So, I mean, clearly that's okay. I
9 think what it really reflects to me is, like I
10 say, a lack of commitment to the specialty, which
11 I think is a -- part of the reason for her lack of
12 motivation to change.

13 On numerous occasions her statement
14 was the only reason I'm finishing the program is
15 because I don't want to be an imposition to my
16 classmates. Well, you're not going to have the
17 motivation to change your behavior if you're not
18 really committed to what you're trying to
19 accomplish, and I think that was -- that was my
20 ongoing concern.

21 I mean, I think you need to make the
22 commitment and make a commitment to change your
23 behavior in order to successfully complete that
24 commitment.

25 DR. CROOM: Is there any question at

1 all about Jackie's work ethic? I mean, you've
2 mentioned these cases where, you know, she has
3 chosen to not be involved. In terms of her work
4 ethic.

5 DR. TALBOT: The only example I have
6 of that is the research project. That was put
7 together at the last second, and since she's
8 completed that presentation, Dr. Maxwell several
9 times has tried to get her participation in
10 actively treating patients or helping medical
11 students, and nobody got responses from her and
12 they took her off of the panel.

13 So I wasn't pushing that. As again
14 though she met -- she's checked that box for the
15 resident research project, but that's the only
16 thing with respect to work ethic.

17 She shows up for her shift. You
18 know, she doesn't say I'm not seeing this patient
19 in clinic, you know, et cetera, et cetera. I
20 don't -- that's not a concern.

21 DR. BARNEY: Do the junior residents
22 have the opportunity to evaluate the seniors in
23 your routine evaluation process?

24 DR. CROOM: No formal evaluation, no.

25 DR. BARNEY: Have there been any

1 other, other than the direct inferences where
2 residents have stated --

3 DR. YAKLIC: Other than junior
4 resident complaints?

5 DR. BARNEY: Yes. Yes.

6 DR. YAKLIC: Formal and in writing,
7 no.

8 DR. TALBOT: And I have witnessed the
9 junior resident mistreatment even -- even in
10 this -- August our intern, Dr. Cook, she berated
11 her about having the history and physical for a
12 nine o'clock C-section not done by seven a.m.,
13 when there would be time after the rounds, and
14 brought that resident to tears, and I said,
15 Jackie, this is one of those situations where you
16 need to back off.

17 This can be done afterward. You
18 pulled her from morning rounds and learning to go
19 complete this history and physical.

20 And so I felt -- I apologized on
21 the -- our intern's behalf, and I did not -- I
22 calmly recommended to Jackie that this is one of
23 those examples we're talking about where you need
24 to back off a little bit.

25 DR. POZNANSKI: Has there been or can

1 there be any resident input regarding termination?

2 I don't know the answer to that.

3 DR. TALBOT: I'm not sure I
4 understand the question.

5 DR. POZNANSKI: Have you sought any
6 resident's input in terms of this decision?

7 DR. YAKLIC: Not formally.

8 DR. TALBOT: Now --

9 DR. POZNANSKI: I don't know if there
10 can be.

11 DR. TALBOT: Now --

12 DR. PAINTER: It's -- it's not
13 appropriate.

14 DR. POZNANSKI: Okay.

15 DR. PAINTER: Obviously on the
16 information that is brought forward anecdotally
17 or, you know, in an instance, obviously it can be
18 shared, but in terms of should they be terminated
19 or not from another training program, no.

20 DR. POZNANSKI: I didn't think so. I
21 was just curious.

22 DR. YAKLIC: Especially not if you're
23 a chief resident.

24 DR. POZNANSKI: Sure.

25 DR. YAKLIC: I mean, if it was a

1 junior resident, you could argue that their
2 chief's input would be a very important part, and
3 I'm a fan of 360, I like that we actually have the
4 formal evaluations from juniors, that's something
5 we might want to talk about, but I think at this
6 point it would be inappropriate to ask them.

7 DR. POZNANSKI: I just didn't know if
8 through the process there had ever been any formal
9 residents' involvements in any of the discussions.

10 DR. YAKLIC: We do have chief
11 residents that sit on our CCC. So, I mean, which
12 in some of the earlier events when she was a
13 second year or third year, there was chief input,
14 but -- so that's through that process.

15 DR. TALBOT: They leave and --

16 DR. POZNANSKI: They were.

17 DR. TALBOT: -- we discuss their
18 class and they don't -- they don't vote.

19 DR. POZNANSKI: Similar to what we
20 do. I was just curious.

21 DR. YAKLIC: And they give input into
22 the junior residents, but they don't get to see
23 that obviously.

24 DR. BARNEY: Have you had any other
25 residents on probation for professionalism

1 predominantly that were able to successfully
2 complete probation and finish the program?

3 DR. YAKLIC: Not that I'm aware of.

4 DR. TALBOT: I don't believe so.

5 Going at least back to the time that I've been
6 associate program director, the only one that
7 deals -- Dr. Hairwood (phonetic), but his was more
8 knowledge, surgery, all that.

9 The one that had significant
10 professional issues was dismissed her second year.
11 And then we've had one that was held back one year
12 and went to family medicine.

13 So, no, we have not had -- and then I
14 guess in the deliberation with the CCC, you know,
15 we have sometimes extended peoples' training.

16 Certainly if it's surgical
17 competency, just needing more experience and more
18 cases, we've extended training, but in a
19 professionalism issue, I don't see where that
20 helps.

21 DR. POZNANSKI: How many residents
22 have been terminated or have been recommended for
23 termination? I guess two different questions.

24 DR. TALBOT: Into?

25 DR. POZNANSKI: At all.

1 DR. TALBOT: At all?

2 DR. POZNANSKI: How many residents
3 have been terminated from the program?

4 DR. YAKLIC: We've terminated one
5 resident in the last -- well, Jackie was the
6 second resident in the ten years that I've been
7 back in the faculty.

8 DR. CROOM: That sounds about right,
9 yeah.

10 DR. YAKLIC: And I don't think there
11 was any in the four or five years before that.
12 That would have been back even before I began, so
13 there's only the two in recent times that I can
14 think of.

15 DR. CROOM: The one from family
16 medicine wasn't terminated, but --

17 DR. TALBOT: No.

18 DR. CROOM: -- he had repeated a year
19 and then left.

20 DR. YAKLIC: And his was related more
21 to clinical skill. I mean, he just -- he wasn't
22 really a proceduralist and wasn't happy in his
23 choice.

24 DR. PAINTER: Other questions for Dr.
25 Talbot or Dr. Yaklic at this stage?

1 DR. CROOM: Just on a couple of the
2 student comments. The one who related to Dr.
3 Galloway, and we never saw a formal written
4 assessment of that scenario, it seems like it's a
5 pretty blatant thing that he might have responded
6 to, and I know the one with my name on it, I don't
7 know. I mean, I'm a --

8 DR. TALBOT: I don't know.

9 DR. CROOM: You know, I guess, you
10 know, if it were presented to me as an insulting
11 remark, like it's suggested here, I clearly would
12 remember it, my skin is not that thick, and I
13 don't even recall this, so I just --

14 DR. TALBOT: I don't know, but it's a
15 perception with --

16 DR. CROOM: Correct.

17 DR. TALBOT: -- the student. So
18 whether it was banter back and forth, what are
19 reading? I don't read, you know, whatever. I
20 don't know, but that -- their perceptions are
21 often very different and they're the paying
22 customer. They don't hold back. They're young
23 and free-spirited and they -- they are in --
24 they're vested, you know, and --

25 DR. CROOM: I understand that, but,

1 again, when we're talking about making critical
2 observations which affect someone's future, you
3 know, it's just -- you need to qualify that,
4 that's all I'm saying.

5 DR. YAKLIC: Well, medicine takes
6 medical student evaluations very seriously.

7 DR. CROOM: Yes, I understand that.

8 DR. TALBOT: As you can tell.

9 DR. YAKLIC: And any -- in all
10 honesty, I think he's -- give a view of what the
11 outsider is seeing. Nursing evaluations are very
12 consistent with the student evaluations. Again,
13 kind of an outsider looking in.

14 You know, I don't think any of these
15 incidents, again, by themselves -- Ted and I both
16 went to bat for Jackie, and then there was
17 pushback from the school of medicine to say that
18 this was an action that we should be considering
19 determination for.

20 This is a resident on probation that
21 has continued performance issues, and we went to
22 bat to say, we've seen some improvement.

23 We think there's a -- you know, some
24 movement in the right direction. She's on
25 probation. We should see how this continues to

1 go.

2 Again, with less than six months left
3 to her program, you know, we now see a turn to the
4 negative again. I'm not saying there isn't
5 progress.

6 I think in the six months Jackie's
7 been on probation, she has improved, but it's
8 been, you know, two steps forward, one step back.
9 One step forward, two steps back.

10 I mean, we -- I can't say -- you
11 know, I wasn't at the CCC meeting. I was actually
12 I think talking about medical student evaluations
13 that day, but it is a scenario where I can't
14 disagree with the recommendation. I sure can't
15 ignore it when they came to me and asked my
16 opinion.

17 This is a strong recommendation from
18 the -- you know, a large portion of our faculty.

19 You know, in the last year, I've been
20 much less clinical than I was previously, so I --
21 you know, I have my own perception, but I honestly
22 can't say that that's what I would base a decision
23 on when a large portion of our faculty, nursing,
24 our medical students continue to say there's
25 concern in the last six months of a resident's

1 tenure, I don't think it's something we can
2 ignore.

3 Like I said, I think Ted has gone
4 through this process and done everything he can as
5 diligently as possible. It's a regrettable
6 situation to be in.

7 I wish perhaps we had been more
8 aggressive when she was a second year in
9 expressing the importance of changing these
10 behaviors, but it doesn't change the fact that
11 we're in the last six months of her chief year,
12 and there's continued significant ongoing concern
13 about her ability to practice medicine
14 independently.

15 I don't know that Ted -- I don't want
16 to speak for him, but, I mean, he has to sign her
17 certificate that says she's okay to practice.

18 In our discussions, he doesn't feel
19 that's something at this point that he's going to
20 be able to do. That forces your hand if the only
21 alternative is to terminate her.

22 I mean, it would have been much
23 easier for us to wait till January after we had
24 our resident back off from maternity leave, but
25 that wouldn't have been fair to Jackie.

1 I mean, we reached a point. If we
2 can't take her off of probation, we only have one
3 other alternative, and, unfortunately, that's
4 termination.

5 DR. POZNANSKI: Were there any
6 indications of these kind of professionalism
7 issues from the previous program?

8 DR. TALBOT: If there were, they're
9 not in her file, and Dr. Galloway admitted -- or,
10 you know, accepted her, interviewed her and
11 brought her into the program.

12 So we had a person that went into
13 psychiatry after his internship here, so that's
14 where that came down, but I don't know. Dr. Mares
15 welcomed the circumstances of her departure.

16 DR. YAKLIC: And Mike has spoken, our
17 previous program director, but there were no
18 concerns raised at that time. Whether there were
19 unraised concerns, I can't answer that question.

20 DR. CROOM: Just one other comment
21 about one of the cases, and I understand that the
22 concern is Jackie's not wanting to participate in
23 the case, but in the clinical scenario, I've
24 reviewed that case, and -- only because the
25 attending was pretty critical that this was a very

1 sick patient.

2 DR. TALBOT: Can you tell me which
3 case you're referring to?

4 DR. CROOM: The abruption. This was
5 someone who was felt to be safe enough to just
6 discharge from another hospital, and certainly
7 someone who you clinically suspect is an
8 abruption, and particularly at 38 weeks, you would
9 never send out of a hospital.

10 I'm curious as to why someone would
11 come to Dayton from Lima for a second opinion. I
12 do know that that attending -- the critical
13 attending is from Lima, I don't know if there's
14 any connection to that.

15 There was no pathological support
16 diagnosis of an abruption. There was not an
17 abruption. There wasn't an abruption found at the
18 time of delivery. Like I said, there was no
19 pathological diagnosis of that.

20 You made it very clear, and I agree
21 with you, it's a difficult diagnosis to make, and
22 I have no problem either way it was managed, but
23 the fact that it was presented in her case as
24 something that it wasn't, I think it's important
25 to point that out.

1 DR. YAKLIC: I think the key is,
2 again, it wasn't a management decision that was
3 the question. And clearly, we could argue back
4 and forth whether or not there was a -- I mean --

5 DR. CROOM: No, I --

6 DR. YAKLIC: -- I don't think that's
7 the point. It wasn't a management decision.

8 DR. CROOM: I'm not -- I -- that's
9 how I opened that comment, but I think the point
10 is that I wanted to make it clear that she did not
11 make a mistake clinically. You can infer that
12 from --

13 DR. TALBOT: And -- I'm not -- I am
14 not accusing her of making a clinical mistake.

15 DR. CROOM: No, no. Dr. Kindig
16 appears to have.

17 DR. TALBOT: Oh, okay. My -- I did
18 not -- I felt I did not have a good diagnosis. I
19 did not suspect abruption. She had no bleeding.
20 She wasn't really contracting. The baby looked
21 great on the monitor.

22 So all these things we were
23 potentially worried about, I do not think -- but
24 based on what I saw when I talked to the patient,
25 I did not feel comfortable in sending her home.

1 And I didn't say, well, we may need
2 to get more imaging and we may need to get more
3 testing and keep you here longer.

4 I don't think that -- the family was
5 fine with that. That was not the question, the --
6 the clinical decision-making and that sort of
7 thing. It was other than --

8 DR. CROOM: And honestly, I was
9 addressing the attending's comment because it
10 sounded like she missed the diagnosis, and I
11 wanted to make that clear, that that didn't
12 happen.

13 DR. TALBOT: That was not my concern.

14 DR. CROOM: No, no, I understand.

15 DR. TALBOT: That might be Dr.
16 Kindig's interpretation, but that was not mine.

17 DR. CROOM: But that's what you read
18 to us.

19 DR. TALBOT: Right. Well, I read her
20 account, yes.

21 DR. CROOM: Right.

22 DR. YAKLIC: Well, clearly the
23 interactions with the family were a concern. I
24 mean, why did they come? We're the region's
25 leader. They came for a second opinion in a

1 tertiary care center and expected to get
2 evaluated.

3 The -- you know, one of the
4 complaints raised to Dr. Belcastro was she never
5 laid hands on them, walked in the room, said
6 they're going to pay an outrageous amount of
7 money, which was not a fact, true fact, and walked
8 out.

9 I don't believe that's what you're
10 supposed to do in a tertiary care center when a
11 patient comes in for a second opinion from a rural
12 hospital --

13 DR. CROOM: I wasn't questioning
14 that.

15 DR. YAKLIC: -- you're supposed to
16 evaluate the patient. That's the unprofessional
17 behavior that we're questioning, not what the
18 diagnosis was or whether the -- I mean, for all
19 intents and purposes, the patient, her -- the
20 diagnosis could have been correct and the patient
21 could have went home and everything could have
22 been fine.

23 That's not the point. She came for
24 an opinion and needed to be evaluated by the
25 senior resident.

1 DR. CROOM: Yeah, I get that.

2 DR. POZNANSKI: If all of the
3 professionalism, communication, interpersonal
4 issues improved substantially or were there, would
5 you be comfortable saying that she could practice
6 as a clinician? Remove all the professionalism
7 issues.

8 DR. TALBOT: You mean remove all of
9 it?

10 DR. POZNANSKI: Right.

11 DR. YAKLIC: Just judging her
12 clinical skills.

13 DR. POZNANSKI: Just purely clinical
14 her ability to practice as a clinician in six
15 months at graduation --

16 DR. TALBOT: Yeah, I don't think --

17 DR. POZNANSKI: -- could you sign
18 that certificate?

19 DR. TALBOT: I think I could. I
20 think the CCC would support that. That's not been
21 the concern.

22 DR. POZNANSKI: Correct. Correct. I
23 just wanted to clarify.

24 DR. TALBOT: But the concern has been
25 patient safety and patient care based on the

1 professionalism inhibiting so much her ability to
2 care for a patient, that it then does put a risk.

3 So what happens if I sign the
4 certificate and she's out, and six months from now
5 one of these interactions occurred? Is her
6 partner every time going to come and be the one to
7 see the patient or is she going to go to other
8 members of the medical staff?

9 I don't know. This is a concern. So
10 it's not the ability to decide what is the
11 diagnosis and what do I need to do and do I need
12 to know how to do it; it's all these other factors
13 that play in that are preventing me from doing
14 that.

15 DR. POZNANSKI: I just wanted to
16 clarify the clinical versus the professionalism.

17 DR. CROOM: One other question in
18 regards to medical students, if I'm not mistaken,
19 someone from the university discussed with our
20 residents, in general, issues with relationships
21 to medical students, is that correct?

22 DR. PAINTER: I'll try to answer your
23 question, Chris. We do and have for the last five
24 or six years, a resident and teacher seminar for
25 all of the incoming interns, and we -- and it's

1 about a three-hour seminar, and they're -- it's
2 usually September or October, and we focus on
3 adult learning, how that's different from --
4 you're not teaching third graders. How to present
5 a patient.

6 The area as we call them microskills
7 teaching, which is teaching on rounding and
8 teaching at the bedside and teaching sort of on
9 the fly, because that's where a lot of good
10 teaching, you know, in the moment comes.

11 And then the fourth area is feedback,
12 and that is how to give feedback to learners,
13 medical students in this case.

14 So, yes, all of our residents are
15 oriented as they enter our program to be able to
16 do that effectively.

17 DR. CROOM: What I was speaking more
18 specifically about is my understanding from what
19 the residents told me was that some representative
20 from the medical school discussed with our
21 residents specifically their interaction with
22 medical students.

23 DR. YAKLIC: With the core
24 evaluations.

25 DR. CROOM: Yeah, and --

1 DR. TALBOT: I did -- I did on
2 multiple occasions.

3 DR. CROOM: I guess my point is there
4 was a culture of that among our residents that
5 needed to be addressed.

6 DR. TALBOT: Right.

7 DR. CROOM: And it's not unique to
8 Jackie.

9 DR. YAKLIC: I'll -- I'll speak to
10 that. There clearly is a culture of that among
11 our residents that we have been addressing for the
12 past several years --

13 DR. CROOM: Right.

14 DR. YAKLIC: -- and I think it has
15 slowly improved. I will say, you know, other
16 residents are named in -- in student complaints.

17 None of them are named as
18 frequently -- I mean, in -- over the -- in the
19 past year evaluations, you know, over 50 percent
20 of the named complaints were Jackie, and we have
21 24 residents.

22 Over half of the named complaints
23 were Jackie, and the level of egregiousness, for
24 lack of a better word, there was no comparison.
25 She was unique in that regard.

1 DR. TALBOT: I would just like to say
2 that obviously I'm picking this up, so I didn't
3 have thought with the last part, because Dr.
4 Galloway would have directly spoken with
5 residents, but since I took that over, I was at a
6 program director's meeting with no names
7 identified for residents, but I read off all of
8 the comments.

9 It was the good, the bad and the
10 ugly, and we went through every single one, and
11 afterwards I had residents come up to me and say,
12 I know, I was up there, I know, and I know the
13 situation. And sometimes I was like, well, you
14 would not believe this student. This is all
15 vengeance, you know.

16 And then other times, it was like I
17 guess I wasn't perceived that way. So we did
18 that. Then individually, Dr. Barhan and I -- we
19 get quarterly these types of statements, and we
20 have a -- if a new name surfaces, we meet with
21 that person.

22 So we met with two second year
23 residents earlier this month. I don't know that
24 Dr. Galloway did that. I don't -- I can't speak
25 and I can't change what happened in the past, but

1 I'm being proactive as much as I can be, because I
2 don't want to keep dealing with this type of
3 thing.

4 DR. CROOM: Right. And from your
5 documentation, it sounded like you had an impact
6 on Jackie from the medical student perspective.

7 DR. TALBOT: I think he did and maybe
8 all it was was more emphasis on her, like this is
9 an intolerable type of thing.

10 DR. POZNANSKI: When you had those
11 conversations, what was Jackie's response to those
12 complaints?

13 DR. TALBOT: Well, I think she said
14 the same to you, but, yeah, I was pretty -- maybe
15 she used the word bitchy to medical students and
16 stuff and so -- but -- and the medical students'
17 accounts, in fairness, it's more than just to the
18 medical students, it's to nurses, it's to junior
19 level residents, senior level residents, it's to
20 faculty.

21 And I remember that instance where
22 it was mentioned her senior resident, Tony, and
23 Tony was upset about it. And another resident
24 just said, well, that's just Jackie being
25 Jackie.

1 And I thought, well, yes, that's
2 true, but that doesn't necessarily mean that --
3 he was truly upset about it, and this is a guy
4 that I never see really get upset. He's kind of
5 happy go lucky and very popular amongst residents.

6 So I think -- like I said, I think as
7 much as I could, I emphasized that that was a very
8 key component in her coming off of probation, and
9 I never would have gone -- I would have been --
10 had nothing to offer at the meeting with Dr. Roman
11 in Dr. Painter's office in mid August with Dr.
12 Yaklic if we didn't see improvement.

13 So I thought here, you know, we're
14 making progress, but like I said, in my mind, that
15 progress seemed to be short-lived based on the
16 incidents.

17 DR. BARNEY: When you said there was
18 improvement, was it lack of negative or was it
19 truly positive, like this person's a good teacher
20 or this person helps me with my work or --

21 DR. TALBOT: It was a lack of the
22 negative.

23 DR. BARNEY: Lack of negative.

24 DR. TALBOT: And then also when they
25 said before that they wouldn't involve her, she

1 wouldn't work with students. Then one had said
2 she did involve -- they did involve her for that
3 student in the OR and had done some teaching,
4 so --

5 DR. YAKLIC: Because of the ongoing
6 concerns, we had more frequent and more direct
7 questions of our residents -- or of our medical
8 students regarding resident behavior.

9 And so there was more direct
10 questions of how was this resident with -- so, you
11 know, there was some clear improvement, I'll say.

12 DR. PAINTER: Other questions at this
13 juncture? You can come back again certainly after
14 Dr. Mares make her presentation and readdress
15 other issues or new issues with Dr. Yaklic and
16 with Dr. Talbot.

17 So if we need to take a break, would
18 somebody just send some sort of -- you know, I
19 need a break for whatever reason.

20 DR. MARES: I would like to take a
21 break.

22 DR. PAINTER: You want to take a
23 break? Okay. We can take a break.

24 (Pause in proceedings.)

25 DR. PAINTER: Dr. Mares, I'll turn

1 the hearing over to you.

2 DR. MARES: Thank you. I'm going to
3 have Dr. Glover, my acting advisor, to start off.

4 DR. GLOVER: So, Doctors, again, my
5 name is Melanie Glover. I've started my 16th year
6 as a physician here at Miami Valley Hospital.

7 I've also participated in clinical
8 duties at Wright-Patterson. Because of my time
9 here, I completed a residency and I also completed
10 my fellowship here.

11 I've had a unique opportunity to be
12 the one in training, meet a lot of students and
13 also be an educator in the attending role.

14 Over this time, I've gotten to know
15 residents from 19 consecutive classes. The 16th
16 since my actual start here and the three that
17 taught me, so my three senior classes. A total of
18 19.

19 And we all come from a lot of
20 different places when we come here to train, and
21 training is never easy for any of us. I know you
22 know this.

23 When we get here, we all have our own
24 unique challenges. And I feel like as I've gotten
25 to know Jackie in her training, and especially

1 through this process, I'm convinced that when
2 Jackie came to us, she was not broken.

3 We have spent a lot of time telling
4 her otherwise. And it -- it pains me to be so
5 invested in this program to feel like we failed
6 someone so miserably.

7 I have long, personal relationships
8 with almost every other attending in this
9 program. Many of them have taught me. I have
10 taught many of them, and many of the others I have
11 worked side by side with as a colleague.

12 Of the newest faculty at Wright
13 State, I don't have a long-standing relationship
14 with Dr. Kindig, and on occasion, many people flip
15 through the base, as is the nature of the base,
16 and so sometimes I don't know them, but by and
17 large, I have long-standing relationships with the
18 faculty.

19 They're good people. They're good
20 doctors, but I think in the case of Dr. Mares,
21 they're making a mistake. Dr. Mares, as you've
22 heard, is accused of having, quote, personality
23 issues.

24 And one of my questions has been, has
25 anyone ever really put forth the effort to get to

1 know her from what she came and the circumstances
2 of her being here and to really understand who
3 this person is.

4 I will be completely forthcoming.
5 When I first met Dr. Mares, I was a bit put off.
6 I found her a little hard to get to know, but
7 instead of using that against her, I challenged
8 myself to try harder to try to get to know this
9 person, because certainly she was in a very
10 difficult position to come from another training
11 program that was completely structured in a
12 different way than this one, and to enter the
13 second year of this program, which is notoriously
14 the most difficult one, and to have no family, no
15 friends, no previous bonding with her resident
16 class because she wasn't an intern with them.

17 To come to this place and be
18 completely alone, and to be asked to catch up and
19 to teach and to kind of fend for yourself.

20 Jackie, and she's -- in our
21 conversations, she has affirmed this. She is an
22 introvert, textbook definition, painfully so.

23 This young doctor struggles with
24 micromanagement. It's a very intimidating sort of
25 situation for her to be in, and she admittedly

1 becomes very frustrated.

2 When she's allowed to have a little
3 room to breathe, her defenses come down and she's
4 able to logically work her way through situations
5 and function very well again, but she has admitted
6 to me that micromanagement is something that she
7 struggles with, and she would like to learn coping
8 mechanisms to help be better under those
9 situations.

10 She -- because of the way this type
11 of management affects her, naturally she does not
12 micromanage those that are working for her.

13 And so she has developed skills by
14 which she cannot be on top of her junior residents
15 and students, but by virtue of the EMR and our
16 ability to call nurses and to call other
17 residents -- and I've done this myself.

18 You can keep track of everything
19 they do on a labor and delivery unit or on a
20 medicine floor and not be there beside them. You
21 can track them in the system, often the means by
22 which she will supervise her team.

23 Dr. Mares being the introverted
24 personality she is, she's not a villain. She's an
25 empath. She feels more than I feel most days, and

1 I think I'm pretty empathetic. I have a big heart
2 and I'm really sensitive.

3 She's got me beat on this one. She
4 bonds with her patients in ways that are superior
5 to almost every resident I have met in 19
6 consecutive classes.

7 Her ability to join them in their
8 journey in the most trying of times is nothing
9 short of exceptional.

10 I feel like as we've listened to the
11 cases described and the stories being told,
12 Jackie, it has been stated, has been given a
13 chance to tell her side, and this much is true.

14 I believe my colleagues have given
15 her the opportunity; however, I question whether
16 those opportunities and those environments felt
17 nurturing and safe to Jackie.

18 It's very difficult for someone to be
19 told you're not doing something well. Especially
20 to be told that -- or to be implied either way
21 that there's something wrong with you and the way
22 you work with other humans.

23 It's very hard then to find trust and
24 be comfortable with the person who has delivered
25 those statements to you.

1 I question to my colleagues their
2 choice of mentor for Dr. Mares. The mentor I have
3 known for sixteen years. He's been my teacher for
4 four years of residency and three years of
5 fellowship.

6 I would consider him a friend because
7 he is my partner, and I know his personality quite
8 well, and they're not a good fit.

9 He is a good person. He is a great
10 mentor. He is a great role model, but it is not
11 what Jackie needed. I feel like she would have
12 been better suited by preferably a female mentor.

13 I think that could have helped let
14 some of the defenses down, and I think it would
15 have been more just to have a mentor who is not
16 directly related to these evaluations that we have
17 discussed and ultimately CCC decisions.

18 I would, myself, find it very
19 difficult to completely trust and be able to
20 confide in someone if I knew that they had that
21 kind of leverage over my career.

22 That's my own personal feeling. And
23 I feel like we, as a community of physicians,
24 failed Jackie Mares when we did not give her an
25 opportunity to connect with a role model who she

1 could potentially have a trusting relationship
2 with and potentially work through some of the
3 difficulties she was having.

4 Jackie's natural tendency when she's
5 confronted or intimidated, and we all face this at
6 different times, you choose whether you fight or
7 whether you take flight.

8 Her tendency more often is to take
9 flight and go into a protective mode.

10 And she has admitted this to me and
11 she has openly expressed to me, again, that she
12 would like assistance in learning how to not rely
13 so much on that instinct, because she finds it
14 difficult when pushed to go into fight mode, she's
15 very misunderstood. It's an uncomfortable place
16 for her to be in. She would like real coaching
17 under these circumstances.

18 I have a lot of information from a
19 he said she said perspective that we can discuss
20 in this meeting regarding the different cases, and
21 some of it I would definitely like to share with
22 you.

23 But one thing I want to impress upon
24 everyone is that not only have I expressed to you
25 Jackie being in an especially delicate position

1 when she started our program, she was really
2 expected to do for herself in ways I think were --
3 it was more than what anyone should ask of any
4 resident in their program.

5 It put her in complicated situations
6 with medical students and other residents. The
7 program Jackie came from, they did not operate as
8 interns.

9 This program is very different. When
10 I graduated -- I'm sorry, when I advanced from my
11 first year, I had performed one hundred and fifty
12 Cesarean deliveries. That's a lot of operating.

13 Now with the numbers as they
14 change -- as they've changed, they're not quite
15 that heavy anymore, but nonetheless, the interns
16 start their second year with a lot of surgical
17 experience under their belt. Her program was not
18 stratified that way.

19 Whenever you moved into second, third
20 years, et cetera, you had rotations that were
21 completely dedicated to be in the OR.

22 When she came here, instead of us
23 being able to say to her, we understand that these
24 are your deficits simply because our programs are
25 structured differently, these are the things that

1 we are going to do to help you catch up.

2 Instead she was told you need to get
3 your numbers if you want to advance, and if you
4 have to, bump someone else.

5 I can't imagine how difficult it must
6 be to be the new person trying to foster
7 relationships within a residency program when
8 everyone's looking at you with a critical eye to
9 be in that position where you then have to jockey
10 for cases.

11 Everyone here is under pressure to
12 perform in the OR as much as possible. We all
13 want to be good surgeons when we graduate, but to
14 have that added pressure -- I haven't seen
15 anywhere in the documentation where anything was
16 offered to Jackie to set her up with a faculty or
17 to ask a private provider if they would volunteer
18 to spend time with her in a special -- a specially
19 formulated rotation just to get her going
20 surgically. That way she could be better
21 integrated into the second year.

22 If there was that effort, I would
23 love for that to be shared with the group, but I
24 don't think it happened.

25 So there were those things that were

1 just technically very difficult for her to take on
2 her own.

3 DR. YAKLIC: Now, you said we could
4 ask questions as we moved along, correct?

5 DR. PAINTER: What I prefer is to let
6 Dr. Glover and Dr. Mares do their part of the
7 presentation that they have, and then ask
8 questions afterwards as opposed to kind of
9 breaking that up. So if you'll continue, Dr.
10 Glover.

11 DR. GLOVER: Thank you, Dr. Painter.
12 So I am concerned that there hasn't been enough
13 proof in her records to convince me that we did
14 what we could to help her catch up from a
15 technical standpoint.

16 But what's more concerning to me is
17 I've really come to feel like there's a dichotomy
18 of expectations when it comes to the professional
19 standards that we, as attendings, are upholding
20 versus what we're expecting of our residents.

21 And, again, a lot of the things we're
22 discussing today, there's a lack of objective
23 data.

24 A lot of it's personal telling of a
25 story, but I have no reason to think that Dr.

1 Mares would lie to me and tell me that another
2 attending, in front of an ER full of physicians,
3 nurses, residents, students; I have no reason to
4 think that she would lie to me and tell me how
5 devastating it was, during these formative middle
6 years of her residency, for an attending physician
7 in our department to stand there and tell her she
8 is a fucking idiot. It is completely
9 unacceptable, and I believe it happened.

10 And I think I have resident
11 documentation that this incident, as Dr. Mares has
12 described to me, can be supported. And I feel
13 like what response came from the department was
14 more of a coverup for that attending's behavior
15 than it was to help her deal with such a
16 devastating blow. Unacceptable.

17 And now we sit here. She's
18 unemployed because we've told her she's not
19 professional. What kind of examples have we set
20 for Dr. Mares? If it's okay for me, as an
21 attending, to tell her she's a fucking idiot and
22 then apologize later and go through the coverup so
23 it doesn't get all the way up to the provost and
24 causes some real problems.

25 She was not broken when she came

1 here, but there are a lot of things, like what
2 I've just described to you, that have happened
3 that I feel like we have done to potentially break
4 her.

5 And in this era of physician burnout,
6 depression and suicide, I can't express to you how
7 many days I have checked in on this doctor, is she
8 okay? Do you feel like someone needs to intervene
9 for her safety?

10 I would like to hope that Dr. Mares
11 nor any of our other residents would ever
12 contemplate a suicide whenever they meet their
13 professional challenges, but I also feel like we
14 need to sit here and be completely honest with
15 ourselves and ask ourselves, is this a near miss?

16 I feel like this poor woman has not
17 been supported. She has not been nurtured. She
18 has been villainized.

19 And I feel like I've done too little
20 on my part. I feel like I should have advocated
21 for her more. I feel like I should have been
22 nosier. I should have butted in. I should have
23 asked more questions whenever it looked like
24 difficulties were occurring, and I didn't. I have
25 failed Dr. Mares in that respect.

1 But I have watched her grow. I have
2 operated. I have gowned up with her. I've
3 watched her hands learn how to perform.

4 I've watched her deliver dead babies
5 and hold them and tell their mothers how beautiful
6 they are.

7 And I've read cards from those
8 patients expressing their thanks to her because
9 she is a very good doctor and a lovely human
10 being.

11 I have some things, if I may, that I
12 would like to give you. Dr. Painter, do I have
13 your permission to hand out some things?

14 DR. PAINTER: Yes.

15 DR. GLOVER: And I have copies for
16 you too, sir. I apologize for all the sticky
17 notes. I did not take my reading glasses to the
18 store and I bought the wrong tabs. One for you,
19 and, Dr. Painter, these are for you.

20 So for the three of you across the
21 table in your blue or red folders, you will find
22 an example of a patient letter to Dr. Mares, and
23 this was a case that was managed here at Miami
24 Valley Hospital.

25 There's also a copy of a family

1 letter from a patient who was cared for at
2 Wright-Patterson Air Force Base.

3 You will find multiple letters of
4 support that have flooded my inbox in the last few
5 days.

6 Many of these are from fellow
7 residents. The one on top is from Dr. Bembry.

8 Dr. Bembry is a hospital-employed
9 physician, as I am, and I think his interest in
10 Jackie's well-being is sincere and deeply rooted.

11 I don't know if you all know Dr.
12 Bembry. He is a passionate man to the point of
13 being bombastic at times, and he, himself, has
14 been reprimanded for behavior in educational
15 situations and has gone through the necessary
16 steps to help reconstitute himself to become a better
17 educator.

18 And he took his experience to
19 genuinely make himself better and to help the
20 people who he's volunteered to train. And so
21 that's a little background on Dr. Bembry for that
22 letter.

23 The others were -- I did not solicit
24 any residents for letters. Like I said, they
25 approached me and these landed in my inbox. And I

1 hope before you make the decision that you have to
2 make that you will have an opportunity to read
3 those.

4 Also in your folder that you're
5 looking at, there's a letter from Dr. Madison. I
6 refer to it as a letter of clarification.

7 Dr. Madison is the faculty physician
8 who did her due diligence and informed Dr. Talbot
9 of Dr. Mares' lack of professionalism on Friday,
10 August 31st, 2018.

11 Dr. Talbot referred to Dr. Madison's
12 written report, and the copy of the e-mail that
13 you now have, you can see that it states, to whom
14 it may concern: I would like to take a few
15 minutes to embellish on the below e-mail I sent to
16 Dr. Talbot two months ago.

17 When I spoke with Jackie after the
18 incident with the general surgery team, it was
19 clear to me that Jackie was remorseful and
20 realized her behavior was inappropriate.

21 While the manner in which she handled
22 the situation was unprofessional, her anger
23 clearly stemmed from her place of trying to do the
24 right thing for her patient and being her
25 patient's advocate.

1 At this moment, I would like to add
2 that this was an incredibly complex patient. I
3 was actually the attending MFM the day that this
4 boiled up, and I wish that I had been the one
5 called instead of Dr. Madison, but that's a common
6 confusion, we don't blame our surgical colleagues
7 for not knowing who to call.

8 DR. POZNANSKI: May I interrupt for
9 just a minute --

10 DR. GLOVER: Yes, please.

11 DR. POZNANSKI: -- so that I could
12 follow along with you? Where -- which page are
13 you looking at?

14 DR. GLOVER: It would be titled
15 Madison. It's in your blue folder. Yes. So this
16 patient was late preterm. She does not have a
17 grasp of our native language.

18 She declined hospital interpretation.
19 Had a supportive husband who was interpreting for
20 her. So culturally, it was a more complicated
21 case.

22 She had had multiple admissions and
23 had gallstone pancreatitis ultimately in the end.

24 And there had been some uncertainty
25 as to how to manage her, because she was, like I

1 said, late preterm, and coming so close to that
2 point with babies where sometimes we just try to
3 conservatively manage, deliver the baby, and then
4 do further interventions for the mom. So I know
5 that had been complicating things.

6 But Dr. Mares, very intuitively, had
7 looked at the clinical information and had begun
8 to realize that not only was this patient
9 miserable with these multiple admissions, but that
10 she was sicker than she had been before, to the
11 point where, with gallstone pancreatitis, this
12 patient was legitimately at risk for preterm
13 birth.

14 She was at risk for significant
15 maternal morbidity, but at this point also had
16 significantly increased risk for maternal
17 mortality.

18 And I, as the attending that day,
19 pushed Dr. Mares very hard. Dr. Mares, please,
20 let's get to the bottom of this. Please talk to
21 them. Let's get a plan. I need to know when
22 she's going to go to the OR. I'm worried, too.

23 So I feel like she was certainly in a
24 high stress situation, that I participated in, and
25 in hindsight, she realized that her behavior was

1 emotionally charged yet still inappropriate.

2 And she took it upon herself to
3 apologize to the team and the nurse before she was
4 even confronted, and I think that speaks volumes
5 for her.

6 I don't know if she had the skills to
7 do that under such a volatile situation when she
8 first joined us as a second year resident, but
9 clearly she had developed the skill set necessary
10 to humble herself, acknowledge that she was
11 mistaken and offer up a sincere apology.

12 So that's Dr. Madison's entry.

13 DR. PAINTER: Do you mind if I share
14 these with Dr. Talbot and Dr. Yaklic?

15 DR. GLOVER: No, please.

16 DR. PAINTER: Then we will all be on
17 the same page.

18 DR. GLOVER: Absolutely. I don't
19 mind at all. Thank you for asking, Dr. Painter.

20 DR. PAINTER: Okay.

21 DR. GLOVER: If you would like me to
22 pause, please just say so. I can see that you're
23 flipping through those.

24 DR. TALBOT: I have a question --

25 DR. GLOVER: I'm sorry, I couldn't

1 hear you.

2 DR. TALBOT: I'm sorry. You had just
3 said something earlier about you weren't
4 soliciting letters --

5 DR. GLOVER: I did not solicit
6 residents for their letters.

7 DR. TALBOT: You asked.

8 DR. GLOVER: I asked.

9 DR. TALBOT: Okay. That's fine. I
10 just was confused.

11 DR. PAINTER: Just a point of
12 clarification; I think everyone's reading. I want
13 to make sure that Dr. Mares has a chance to speak
14 on her behalf, so --

15 DR. GLOVER: Would you like me to
16 continue?

17 DR. PAINTER: If you have more, yes.

18 DR. GLOVER: I have more.

19 DR. PAINTER: Okay. Please continue
20 then, yes.

21 DR. GLOVER: Yes. I just wanted to
22 be polite.

23 DR. PAINTER: I couldn't tell whether
24 you were finished or whether you were --

25 DR. GLOVER: No, no, I was just

1 giving them some time.

2 DR. PAINTER: Okay.

3 DR. GLOVER: So in your other folder,
4 I have included a couple of representative
5 articles, and with your roles in leadership in
6 resident education, I anticipate you've read far
7 more about physician burnout and depression than I
8 have, but I just wanted to point out to the
9 committee that much of what is described in
10 burnout and depression amongst physicians has
11 actually been well-characterized by Dr. Talbot
12 today; however, he has not mentioned the potential
13 of burnout in Jackie.

14 In the first article titled Physician
15 Burnout, its origin, symptoms and five main
16 causes, it very clearly explains cardinal symptoms
17 of physician burnout.

18 One being exhaustion. Another being
19 depersonalization and another being lack of
20 efficacy. I think every resident is routinely
21 exhausted, but I think that's something that's
22 really been pointed out as special to Dr. Mares,
23 and her experience is how she's become
24 depersonalized during parts of her training
25 process. Particularly as signaled by cynicism,

1 sarcasm, the need to vent about your job and
2 people involved in your job.

3 Certainly there are causes of burnout
4 that are numerable. The big ones include the
5 actual practice of clinical medicine, what your
6 specific job might be and the demands of that job,
7 but this author goes to the effort to also
8 describe one of the top main causes of burnout is
9 the conditioning of our medical education and also
10 the leadership skills of your immediate
11 supervisors.

12 So I certainly feel like there is
13 potential that Jackie Mares was burned out. In
14 fact, one of her junior residents, who is very
15 young, but very insightful, even mentioned that in
16 one of her letters.

17 One of her first impressions of Dr.
18 Mares was that she was burned out.

19 So I feel like one of our junior
20 residents recognized this, but we, as her
21 attending physicians, potentially failed to
22 recognize it and certainly didn't address it in a
23 more constructive manner.

24 Our other article for reference is
25 from Current Psychiatry. It's titled Depression

1 and Suicide Among Physicians. Predictors of
2 depression in physicians as referred to in table
3 one, the top of the list, difficult relationships
4 with senior doctors, staff and/or patients.

5 I keep pounding away at this point
6 because this is the reason that Jackie Mares has
7 been terminated from her role as a physician in
8 our training program, but I'd like to encourage
9 you before you make your decision today to please
10 look at her CV, look at the paper trail that
11 followed Jackie before she joined us.

12 She was a mentor. She was in
13 position to educate others, and she seemed to have
14 a real passion for it, and it makes me question
15 all of us in this room what happened after Jackie
16 came here that extinguished that fire?

17 She had a natural drive to be a
18 teacher and to teach others the things that she
19 loves. She has an interest in neuroscience and
20 psychiatry in addition to OB-GYN.

21 It's clear in her CV that she was
22 passionate about sharing the knowledge that she
23 had gained with others, and I don't expect someone
24 to lose passion for a field they love simply
25 because they become a resident. I think it's much

1 more complicated than that.

2 So I challenge you to ask yourselves
3 if perhaps her own mental and emotional well-being
4 could have played a role in this and if we were
5 being appropriately supportive of her.

6 This article also refers to barriers
7 for treatment. Many in this room may have -- I
8 don't know your personal stories, I can only tell
9 you mine.

10 It says physicians are hesitant to
11 seek mental health treatment. They may fear
12 social stigma and could have trouble finding a
13 provider who they trust but is not a colleague.

14 Physicians might be concerned about
15 confidentiality and fear recrimination by
16 colleagues, facilities and their licensing
17 Boards.

18 I can attest to this, I've had the
19 conversation with any number of people, whether
20 it's people I know personally or people that I
21 have a kinship with on large social media groups.

22 This is a huge concern amongst
23 physicians today, and we're all trying to figure
24 out how do we seek the support we need in our own
25 mental health whenever we fear recrimination.

1 And if you look at table two on this
2 article, it refers to manifestations of mental
3 illness in physicians. And the top of the list
4 being severe irritability, anger resulting in
5 intrapersonal conflict.

6 Now, I'm not suggesting that Dr.
7 Mares is mentally ill, that's not the point I'm
8 trying to make. It's not my judgment to make.

9 The point I'm trying to make is did
10 we do our due diligence to prove to ourselves that
11 she's mentally well.

12 When you confront a physician with
13 the question, are you well? How are you doing?
14 How -- mentally, how are you holding up?

15 Many of us -- I would dare say most
16 of us would probably answer with, I'm fine, things
17 are good. I don't think we're going to divulge
18 our personal doubts and emotions unless we're in a
19 trusting and nurturing environment with an
20 interpersonal relationship with a person who's
21 asking the question.

22 The other thing contained in this
23 particular folder are in the form of e-mails, and
24 I feel like these would be important for you to
25 review at some point in the process.

1 At the top, the first e-mail that you
2 see is a correspondence between Dr. Ing to Dr. Lo
3 to Dr. Talbot.

4 DR. BARNEY: Can I ask you something?

5 DR. GLOVER: Yes, please.

6 DR. BARNEY: Who's Dr. Ing? I don't
7 know that person.

8 DR. TALBOT: Yeah, he graduated when
9 I did.

10 DR. GLOVER: Dr. Ing was a chief
11 resident in our program when Dr. Mares joined us
12 as a second year.

13 DR. BARNEY: Okay. Thank you.

14 DR. GLOVER: Dr. Ing and Dr. Mares,
15 if I remember correctly, were together for
16 approximately half of the year, and if I am also
17 remembering correctly, she had one other chief
18 resident for the other half of the year, and
19 that's a bit unusual.

20 Typically you have a more diverse
21 experience with your chiefs, but sometimes the
22 rotations do line up in such a way that that
23 happens.

24 And I can speak to the tension
25 between Dr. Ing and Dr. Mares. Sometimes that was

1 apparent whenever you were an attending physician
2 working with them; however, I do have my own
3 personal experience to reflect upon.

4 When one of my interns, when I was a
5 chief, had a similar experience. This particular
6 intern was with one of my classmates for six
7 months, and then a couple others of us had her for
8 the other six months.

9 And the resident that I had
10 experience with is, ironically, a lot like Dr.
11 Mares, very introverted, incredibly bright,
12 well-versed in other topics that many of us don't
13 know a lot about, and she was with my classmate
14 for the first six months of her residency, and
15 during that period, I realized the kind of abuse
16 that she was getting from her chief and how she
17 wasn't fostering her.

18 And when I was able to have my
19 educational experience with this intern, it was a
20 lot of hard work. She didn't trust me. I had to
21 beg her, please trust me not to hurt you. Please
22 trust me to teach you.

23 I'm not going to let -- I'm not going
24 to go place the blame on you. I'm the head of
25 this service. Everything goes through me. I'm

1 going to protect you.

2 And the reason I'm telling you my own
3 personal account is just to help you understand my
4 perspective in some of the difficulties in the
5 relationship between Dr. Ing and Dr. Mares.

6 Dr. Ing's teaching style, it wasn't
7 wrong. She was a good chief resident, but it was
8 a tough fit for Dr. Mares, and this can really
9 wear a resident down very quickly whenever they're
10 always in conflict or confrontation with their
11 chief resident.

12 But despite this, despite the tension
13 in their relationship, Dr. Ing reached out to Dr.
14 Lo and Dr. Talbot about Dr. Mares, and the
15 incident that I described to you earlier about the
16 attending physician defaming her with the
17 profanity that she used in the ER.

18 So this is what this e-mail is
19 referring to.

20 DR. YAKLIC: Where is that, what tab?

21 DR. GLOVER: It is titled e-mails.

22 And, again, I apologize for the sticky notes. In
23 addition to this e-mail --

24 DR. YAKLIC: Is this -- so where --

25 DR. TALBOT: It says to Melanie

1 Glover, and then it says hi, Dr. Lo and Talbot.

2 DR. GLOVER: That's because Dr. Mares
3 forwarded it to me.

4 DR. TALBOT: I've never seen it
5 before.

6 DR. GLOVER: And it has a mark here
7 at the top, on May 18th, 2017, at 7:47, Lisa Ing
8 at her address.

9 DR. TALBOT: I must've just -- I
10 didn't ever see this, as I recall, but maybe she
11 sent it to Dr. Lo.

12 DR. GLOVER: Dr. Lo apparently
13 received this e-mail. As I've included in your
14 packet is an e-mail from Dr. Ing.

15 DR. BARNEY: Sorry, who's Dr. Lo?

16 DR. TALBOT: Dr. Lo is a faculty.
17 She's the other associate program director at the
18 Wright-Patterson Air Force Base.

19 DR. BARNEY: Thanks.

20 DR. GLOVER: It's a -- a long
21 correspondence between Dr. Ing and Dr. Lo, and
22 then also included is Dr. Lo's reported
23 correspondence with Drs. Yaklic, Galloway and
24 Talbot.

25 DR. BARNEY: Can you tell me who's on

1 competency committee? Because I don't really know
2 the names of the people.

3 DR. TALBOT: Yeah. I mean, we could
4 get you a list.

5 DR. BARNEY: Okay. Are any of these
6 people that --

7 DR. TALBOT: Dr. Lo is on competency
8 committee.

9 DR. BARNEY: Okay.

10 DR. YAKLIC: Dr. Kindig is not. Dr.
11 Lo is.

12 DR. BARNEY: Are you on the
13 committee, Dr. Glover?

14 DR. GLOVER: No.

15 DR. TALBOT: Dr. McKenna is on the
16 committees. Dr. Towers.

17 DR. CROOM: Dr. Galloway.

18 DR. TALBOT: Dr. Galloway, Dr. --
19 from the base, Dr. Massengill.

20 DR. CROOM: Dr. Barhan.

21 DR. TALBOT: Dr. Barhan, and then
22 Helen Bartlett is a nurse in labor and delivery.
23 Rose Maxwell, our research professor, and Dr.
24 Yaklic, so that would be it.

25 DR. POZNANSKI: And who was the

1 assigned mentor?

2 DR. TALBOT: Dr. McKenna and then Dr.
3 Croom were --

4 (Thereupon, the court reporter
5 interrupted the proceedings.)

6 DR. POZNANSKI: I asked who the
7 assigned mentor was.

8 DR. BARNEY: Was there an attempt to
9 assign a mentor to Jackie prior to her
10 probationary period?

11 DR. GLOVER: Am I allowed to ask
12 that?

13 DR. PAINTER: Actually if you're a
14 witness, you can certainly give information --

15 DR. GLOVER: But I'm also her
16 advisor.

17 DR. PAINTER: You're an advisor to
18 her.

19 DR. GLOVER: Jackie, if you'd like to
20 ask that question, the floor is yours.

21 DR. MARES: So was I given a mentor
22 prior to being put on probation?

23 DR. TALBOT: Yes, at the letter of
24 warning I believe is when. I'd have to look,
25 because this was under Dr. Galloway.

1 DR. MARES: Prior to that.

2 DR. TALBOT: Prior to the letter of
3 warning? I'm -- yes, it says -- in the letter of
4 warning it says the monitoring and mentoring with
5 Dr. McKenna, and I know that you saw him and then
6 ultimately gravitated to also meeting with Dr.
7 Croom.

8 DR. MARES: So then prior to that, I
9 did not have a mentor, correct?

10 (Thereupon, the court reporter
11 interrupted the proceedings.)

12 DR. YAKLIC: I asked her if she was
13 assigned a mentor in the second year.

14 DR. TALBOT: I do know our policy was
15 instituted that all the interns do get assigned a
16 mentor. I don't know whether at the time that
17 this -- if this was before that policy or whether
18 it didn't -- because she came in as a second year.

19 That would be something Dr. Galloway
20 would know.

21 DR. BARNEY: So currently do the
22 interns all have a mentor assigned --

23 DR. TALBOT: Yes.

24 DR. BARNEY: -- as part of --

25 DR. TALBOT: Yes.

1 DR. YAKLIC: So we've done that for
2 at least two years. I don't know if we did it
3 three years ago, but I believe we did.

4 DR. POZNANSKI: Were you aware of the
5 mentor?

6 DR. YAKLIC: Did you ask for one?

7 DR. MARES: I didn't have a mentor
8 that I was aware of. No, I did not specifically
9 ask for one.

10 DR. POZNANSKI: What was the length
11 of time between the letter of warning and
12 probation?

13 DR. TALBOT: The letter of warning
14 was in May of 2017, May 15th, and probation was
15 March 8th, 2018.

16 DR. POZNANSKI: Okay.

17 DR. YAKLIC: Just for clarification,
18 the CCC also includes Dr. Nagy --

19 DR. PAINTER: Can you speak up?

20 DR. YAKLIC: Dr. Nagy, N A G Y, she
21 was a former resident on the base and also was on
22 the CCC.

23 DR. GLOVER: I know your time is
24 precious today. If you'd like, I can proceed, or,
25 again, if you need me to pause, I will. I feel

1 like I need to offer to you some account of some
2 of these specific cases that have been brought
3 against Jackie as means by which to support her
4 termination.

5 If we can refer back to that patient
6 that had the questionable abruption, whom Dr.
7 Talbot and Dr. Kindig were the consecutive
8 attendings, I did not hear in Dr. Talbot's
9 rendition of the account that the mother of this
10 patient had gone so far to say, I'm going to go up
11 so that you don't falsify records and lie about
12 her pain.

13 This is a nurse's personal account to
14 me in a conversation about this case as she was
15 trying to explain to me in detail how rude and
16 threatening the patient's mother had been to Dr.
17 Mares in the triage.

18 So I wanted -- and, again, I can't --
19 I can't give you documentation because this is a
20 personal account; however, in trying to respect
21 this nurse's privacy, I can tell you that she gave
22 her account to Dr. Talbot upon request, and that
23 she is someone who -- she is a very senior nurse
24 on labor and delivery.

25 She's been doing this job for decades

1 and she was a nurse present during all of my
2 training. I feel like I have a very good
3 relationship with her, and she is never anything
4 but fair to the residents.

5 She's never played games. She calls
6 us out whenever we're out of line, and she
7 supports us when we're in the right.

8 And in her account of that particular
9 story, she said to me, Dr. Glover, this was no
10 different really than so many of the other cases
11 we have come through labor and delivery. You know
12 how it is up there. This happens all the time.

13 But what was exceptional was how rude
14 this mother was to Dr. Mares, and she said I felt
15 like Dr. Mares had represented appropriately the
16 assessment of that patient and plan up until that
17 point.

18 Mind you this person had been in
19 triage for six hours. So she had technically been
20 under supervisory care for a very long time.

21 She said that Dr. Mares represented
22 the plan and was polite and professional to the
23 patient and her family as was -- were the other
24 two junior residents.

25 This nurse told me that she stepped

1 out to ask Dr. Talbot to come to the bedside
2 because the situation was escalating, and in her
3 description to me she did it not because she had
4 doubt in her residents, but because she wanted to
5 protect them.

6 And that's what we do as attending
7 physicians whenever situations escalate, we step
8 in and protect our own while giving quality care
9 to our patients and their families.

10 She said the initial response she got
11 from Dr. Talbot was to have Dr. Mares call him.
12 So as instructed, she went back to the bedside
13 with Dr. Mares, and before she could relay the
14 message, she said that Dr. Talbot presented
15 himself to the bedside, and, as his right as the
16 attending physician, made a plan to keep her.

17 That's her account of the story. But
18 she said in no way were any of the residents ever
19 inappropriate with this family.

20 And the family dynamic is rather
21 complicated. The patient was lying in bed,
22 appropriately medicated and silent, not responding
23 for herself.

24 Her partner also not responding. It
25 was the mother who was rude to our residents who

1 was representing the patient. So thank you for
2 allowing me to add a little clarification, I hope,
3 to that.

4 We've already discussed, I hope, some
5 clarifying thoughts for the pancreatitis case as
6 well, and I just realized, if you would please
7 respect the privacy of the nurse, I do have a copy
8 of the e-mail that she sent to Dr. Talbot of her
9 account of that matter. Actually, Dr. Croom, if
10 you could pass those down.

11 Before I leave this case, I just want
12 to beg you all to reconsider this nurse's account
13 again, what she says that the patient threatened
14 to accuse them of falsifying a medical record and
15 lying about her daughter's clinical status,
16 because this is the same patient -- or, I'm
17 sorry -- this is the same person who had the
18 conversation as documented per Dr. Belcastro.

19 So for what that's worth, I'd like
20 you to consider it.

21 I do want to point out that in Dr.
22 Barhan's response to Dr. Talbot in the e-mail from
23 Dr. Belcastro regarding this patient, Dr. Barhan,
24 much to her credit, made a statement that's very
25 simple, but really stands out to me when she said

1 this is real good material for teaching, and I
2 completely agree with her.

3 I would argue that instead of using
4 this as a means by which to terminate a resident
5 who is dealing with a very, very difficult patient
6 interaction, that perhaps we could have gathered
7 ourselves to make a teaching experience occur.

8 She's certainly mature enough in her
9 clinical training to be able to advance to
10 learning how to deal more with a difficult
11 patient.

12 It takes a lot of years and a lot of
13 mentoring to learn how to do that, but I feel like
14 Dr. Mares was ready at that time, and Dr. Barhan
15 made a very good point.

16 The other e-mail that I included was
17 from Dr. Talbot to Dr. Mares, and it -- I won't
18 berate you with going through it because it
19 discusses the things that we've already discussed
20 regarding unprofessional behavior with medical
21 students, nurses, residents, the particular cases,
22 but it's outstanding to me that Jackie, if I'm
23 remembering correctly, had her meeting with Ty and
24 Dr. Talbot on October 4th, followed with an
25 official letter of dismissal on October 5th.

1 On October 8th, I believe an e-mail
2 trail could be confirmed to show that Jackie
3 e-mailed Dr. Talbot to inform him of her due
4 process decision, and at that time she asked him
5 for a detailed account of the accusations that had
6 led to her dismissal.

7 That was October 8th, three days
8 after receipt of the letter, four days after their
9 meeting.

10 The following day, Dr. Talbot
11 e-mailed Jackie to request -- to appropriately
12 request, I might add, that she use her Wright
13 State University account. So a protective
14 extension. We appreciate that, Dr. Talbot.

15 That was the 9th of October. It
16 wasn't until the 21st of October that Jackie
17 e-mailed Dr. Talbot again to follow up requesting
18 for the detailed account the terms of her
19 dismissal.

20 It was on the 22nd that Dr. Talbot
21 sent the e-mail that I've included in your folder.
22 And then finally on the 31st Jackie e-mailed in
23 return that she will not challenge that these
24 events occurred. She's owned them, they're hers,
25 but she would like to discuss the details in front

1 of the appeals committee. That's what brought us
2 here with regard to these e-mails that I have
3 mentioned.

4 Are there any questions for me at
5 this point or do I need to pause?

6 DR. PAINTER: Do you have any more
7 information or are you at an end of --

8 DR. GLOVER: We're nearing the end.

9 DR. PAINTER: Okay.

10 DR. GLOVER: I just want to point
11 out, and this is my opinion as I'm trying to learn
12 about this process, I've never been a program
13 director or an associate program director.

14 I've never been a faculty involved in
15 these things, but as I come through Jackie's file
16 and I read the letters from her program directors,
17 I read the evaluations from the CCC, there's one
18 thing that I can never piece together for myself,
19 because as I'm reading these, I ask myself, had I
20 been asked to be her mentor, would I be able to
21 evaluate her file and pull from that file clear
22 objective benchmarks that she needed to meet in
23 order for me to mentor her and help her succeed,
24 and I'll be quite honest with you, I have not been
25 able to do that.

1 I have read over and over, I've
2 highlighted, I've made notes, and there are always
3 references to the manual, the policy, the
4 procedure, the number. But as far as explicit
5 examples, Jackie, we would like to see you improve
6 your professionalism with medical students by
7 engaging in these activities, I can't find it.

8 And I feel if I had been asked to be
9 her mentor, I would have had to have put forth
10 that effort to some way try to extract from the
11 committee and the directors exactly what it was
12 being tasked upon me to help her with.

13 Now, the mentors who were assigned to
14 her, I'm not aware at any time that they were
15 given explicit objective information as to how to
16 help her.

17 They were told that they needed to
18 meet with her monthly and mentor her, and that
19 seems pretty vague to me.

20 And I think with that, I'll allow
21 Jackie, if there's anything that you want to add
22 on your behalf.

23 DR. MARES: Sure. I don't feel like
24 I have much to say at this point in time. I think
25 that everything has been clearly stated by both

1 sides.

2 As I have said before and as Dr.
3 Glover has mentioned, you know, I've never denied
4 that any of these things have happened.

5 I don't think in my mind that I've
6 underplayed them at all. I've always owned them.
7 I was completely atrocious to medical students in
8 the second year. I don't deny that. It's
9 absolutely true.

10 But I think that what's not pointed
11 out is how much improvement I tried to make since
12 then, and I feel like I did the best that I could
13 with, you know, what I thought I had to offer in
14 terms of trying to improve on everything that I
15 was told about.

16 And I think that even if you read
17 through everything, even the letters from the
18 clinical competency committee, et cetera,
19 everybody comments on how I continued to make
20 improvements, and I still feel like to this day I
21 continue to make improvements.

22 You know, I'm not going to be perfect
23 anytime soon or likely ever, but I do want to be
24 better. I don't want to have these types of
25 problems.

1 So I have tried to continue to figure
2 out what these are. It's apparent to me with just
3 kind of how the situation was handled, that I
4 likely have some sort of blind spot to how people
5 perceive situations and how I perceive situations,
6 because I feel like they're very different.

7 So since being fired, I have elicited
8 the help of a counselor that I've met with
9 regularly for coaching on professionalism and
10 communication, and, you know, I want to continue
11 to make strides in that regardless of, you know,
12 whatever happens today. But I just wanted to
13 point that out.

14 I don't think I have anything else to
15 say.

16 DR. PAINTER: Okay. Questions from
17 the panel?

18 DR. BARNEY: Jackie, did you at the
19 time that you were given a letter of warning and
20 then subsequently placed on probation and offered
21 the opportunity to seek professional help, did
22 you --

23 DR. MARES: I did.

24 DR. BARNEY: -- understand what the
25 professional help options were for you and that

1 that would be arranged for you and you weren't
2 going to -- you weren't going to be financially
3 burdened by this opportunity or something else
4 getting in the way of you seeking that?

5 DR. MARES: No, I wouldn't say that I
6 was fully aware of that. You know, I got this
7 warning letter obviously that you guys saw that
8 said, you know, meet monthly with Dr. McKenna,
9 which I did every month, and frequently more times
10 than that.

11 And to meet regularly with Dr.
12 Galloway, who then transitioned to Dr. Talbot,
13 which I also did, and it recommended that I go to
14 see a physician, which I also did.

15 And I see that that letter isn't in
16 here, but I have a letter from the physician that
17 I saw, but I can easily get a copy of, but I did
18 go and see a physician when it was recommended to
19 me.

20 And, yes, people would always be like
21 we have counseling available to you, but that was
22 it. And I think for a while I didn't think that
23 counseling would be helpful to me. I didn't feel
24 like I had a problem.

25 You know, I felt like there was just

1 a lot of extenuating circumstances, a lot of
2 people weren't understanding, and part of that's
3 true and part of that's probably not true, but,
4 no, I don't think I understood kind of maybe
5 everything that they were trying to offer.

6 DR. BARNEY: Did you feel that you
7 had the opportunity to seek help from an advocate
8 early on in your residency, an attending, a senior
9 resident that -- that could speak on your behalf
10 when there were questions? Or did you feel you
11 had to be appointed an official mentor to have a
12 mentor?

13 DR. MARES: I think I just didn't
14 know. I think I came into the second year and
15 just tried to do what they told me to do.

16 As a second year, you don't really
17 have a relationship with attendings or with other
18 people besides your co-residents, so I didn't feel
19 comfortable going to any of them and that I didn't
20 know them. I didn't know anything about them.
21 It felt awkward to me be, like, hey, do you want
22 to be my mentor.

23 And then in terms of chief residents,
24 I guess I never really thought of them in that
25 way, you know, since I was a chief resident, I

1 didn't see myself going that way, but at the time
2 I didn't appreciate that.

3 (Thereupon, the court reporter
4 interrupted the proceedings.)

5 DR. YAKLIC: I asked her did she meet
6 with Dr. Galloway, our program director, on a
7 regular basis. Because I believe the intent was
8 that he was functioning as your mentor as you
9 transferred into second.

10 DR. MARES: I think I met with him
11 every three to six months.

12 DR. YAKLIC: Formally?

13 DR. MARES: Right, formally for my
14 feedback on clinical competency committee and what
15 they thought.

16 DR. POZNANSKI: Throughout several of
17 these comments that I've read and that have been
18 shared, there have been many comments that
19 patients come first and that you've been a big
20 patient advocate, and what has struck me of late
21 that appears to be different is the subject of
22 patient abandonment, and you were one of the ones
23 who took care of those patients and recusing
24 yourself from those. I'm hoping to get some
25 clarification as to why that was the chosen

1 action.

2 DR. MARES: Sure. So in the first
3 instance with the patient in triage, I came in
4 late that day, we were working strange hours,
5 because we had all of our chief class, aside from
6 myself and another one, out at the Air Force
7 district meeting. So one of us was covering it.
8 So one of us were covering days for quite a few
9 days while they were gone.

10 I came in Saturday night. I received
11 checkout from the chief who was on, and I saw the
12 patient was in triage, and I asked, you know, new
13 or old, do you know anything about her?

14 And the chief on at that time wasn't
15 familiar with her. So I asked the under level
16 resident to conditionally take care of triage
17 patients.

18 In this case it was a term patient,
19 so they're seen first by an intern and then
20 they're managed by the third year. And then in
21 terms of admission or discharge, it's run through
22 the chief resident and then the attending.

23 So I was aware that the patient had
24 already been there for six hours by the time that
25 I arrived, and they had already kind of done their

1 workup. They had done initial treatment. They
2 explained to me kind of all of her course, and,
3 you know, I agreed that they had kind of done
4 their due diligence.

5 They had, you know, safely ruled out
6 major things like abruption, et cetera. And that
7 they had given her Tylenol and that she had slept
8 for several hours in triage.

9 So I said, okay, staying or going,
10 and they said that, you know, they felt that since
11 they gave her Tylenol and she slept for several
12 hours, that she was a candidate for discharge
13 home, and I agreed and then spoke with the
14 attending, who so happened to be Dr. Talbot, and
15 he also agreed the plan was to send the patient
16 home.

17 The first year went and spoke with
18 the patient, as is what is usually done at our
19 program, and then he elicited the help of the
20 third year because he felt like he wasn't able to
21 get through to this patient and their family.

22 And then I was called by the third
23 year who said that the patient asked to go over
24 the chain of command, and that they were asking to
25 speak with me.

1 So I went and spoke to the mother,
2 too, because I was asked to. I did not personally
3 evaluate the patient myself, I mean, obviously she
4 was in the room, but I went up to speak to the
5 mother because I was asked to do that.

6 DR. POZNANSKI: Is it customary to --
7 as a third year to evaluate the patients?

8 THE WITNESS: No. We just receive
9 phone calls from them. I mean, we're a part of
10 their care, but we're already a part of their --

11 DR. YAKLIC: Jackie, as a third year,
12 aren't you responsible for overseeing everything
13 that occurs on your service?

14 DR. MARES: Right.

15 DR. YAKLIC: If there's a question
16 from the care being performed by any of your
17 junior residents, aren't you responsible for
18 overseeing what's occurring?

19 DR. MARES: So let me rephrase that.
20 I felt as if you were asking is it typical for me
21 to oversee, as in go to the bedside and personally
22 evaluate.

23 DR. YAKLIC: And that's my point. If
24 there's a question about the evaluation that's
25 been performed by one of your junior residents,

1 the buck stops with the chief.

2 DR. MARES: I agree.

3 DR. YAKLIC: Right? You are
4 responsible for overseeing all care, and if that
5 means reevaluating a patient, that is what you
6 would expect to occur, right?

7 DR. MARES: Correct. And what I'm
8 saying is that I did not have a problem with the
9 assessment that my team, myself or the attending
10 had made.

11 So when I saw her, I'm sure we spoke
12 with the mother, and I did not reassess the
13 patient. And at that point, the mother was
14 already very angry, and at that point in the
15 conversation she was literally standing so close
16 to my face that I couldn't even look her in both
17 eyes at once. I could only look at one eye.

18 And she was very aggressive, and it
19 became clear to me, even through trying to explain
20 calmly, you know, what our thoughts were like, you
21 know, when she came in with pain and we needed to
22 appreciate that, but she improved with Tylenol,
23 and we feel like we could give her Tylenol or
24 other antiemetics and she can go home with that,
25 and obviously come back if there's a problem. We

1 felt comfortable going home.

2 The reference to, you know, how much
3 it costs, like I did make a reference later to,
4 you know, the cost of staying overnight, saying
5 that, you know, it's not absolutely free and you
6 would get the same medications, but that wasn't
7 like a point of you have to go home or it's going
8 to cost you thirteen thousand dollars.

9 And then ultimately the conclusion
10 that we came to was that they felt comfortable
11 with the Tylenol and how it had helped her pain.
12 They didn't feel comfortable going home until they
13 had already tried the oral medications that they
14 were going to be sent home with.

15 So the decision before Dr. Talbot
16 even came into the room was that the patient would
17 stay and receive oral medications. And I had
18 spoken with the nurse about the orals, and I was
19 pretty much done with that encounter.

20 Then the attending walked in and
21 announced their plan, and obviously whatever they
22 want to do is whatever we do, and that's what we
23 did.

24 So, you know, I went to my first and
25 third year, I said, you know, transition over

1 to -- I spoke with the nurse to kind of make sure
2 we had tried that medication on her, you know, in
3 terms of how the patient is doing.

4 So the nurse very diligently
5 documented about every hour to every two hours, is
6 the patient sleeping, no concerns, things like
7 that. Just making sure that we had all of our
8 documentation on board because I knew that it was
9 a very difficult patient.

10 And then in the morning, the first
11 year and third year had seen her again, and,
12 again, all agreed. The nurse said the patient
13 pretty much slept through the night and that she
14 was fine to go home. And so that was the plan
15 that was presented to the attending.

16 I received a call later that morning
17 that -- from Dr. Kindig that, you know, she wanted
18 me to come and talk, you know, with the family
19 about this patient's course of care.

20 And I said that I didn't feel like I
21 was the best person to do that because, you know,
22 the last time I had seen the patient, we had come
23 up with a plan, we were comfortable with that plan
24 and then the plan changed.

25 And so I kind of felt like I had been

1 made, and I didn't have the trust of the patient
2 anymore, and it seemed strange to them to be the
3 one to go back in there and try to convince them
4 of something else now.

5 So I offered her the next most senior
6 resident, my third year, who then continued in the
7 care with Dr. Kindig regarding that patient, and I
8 didn't hear anything else about that patient.

9 Dr. Kindig didn't speak to me again
10 about her. She never said that she had a problem
11 with how I sent the third year instead of going to
12 see her myself.

13 The only reason I even found out that
14 they were doing a C-section is because I was
15 called by the nurses asking whose gloves, whose
16 cards to pull, and I said, well, I wouldn't pull
17 mine because I didn't even know this was
18 happening, so I assumed I wasn't part of this.

19 And I was never asked to be part of
20 the surgery by Dr. Kindig, by the third year, by
21 anybody. And then that was it.

22 That's all I ever heard of this
23 situation until I was fired, and then more of it
24 came to light and then I was told actually by the
25 third year that the family had complained. I

1 didn't even know about that either.

2 So that's the one situation, and how
3 I felt in that situation. I appreciate that I
4 probably could have continued to go with that
5 family, but at that time, I felt like I had other
6 competent residents who could do that, and I just
7 felt like I just didn't have any credibility left
8 with that family after the nights -- after the
9 preceding events the night before. So that was
10 the one situation.

11 The second situation with the
12 gallstone pancreatitis, I was present and pretty
13 much, more or less, responsible for her care for
14 the entire week that she was with us.

15 We had admitted her back on a Monday
16 and her surgery wasn't until the next weekend, so
17 many, many days later.

18 I had taken that responsibility
19 largely from the junior residents because we were
20 having a lot of difficulties, as is normal with
21 anybody just kind of getting ahold of the
22 different consultant teams. It was taking up a
23 lot of her time. I could see it was very
24 stressful to her, and we had a very busy service
25 otherwise.

1 So I was the main person responsible
2 for kind of coordinating all of the care, all of
3 the consultants, and with everything that
4 happened, we had a very difficult time getting in
5 touch with surgery on a regular basis,
6 communicating with surgery, kind of knowing what
7 the plans were, which was very uncomfortable for
8 everybody involved.

9 You know, from our team as the
10 primary care team trying to tell the patient
11 what's going on, and we had very little idea.
12 That was very stressful.

13 You know, the patient, even though
14 she didn't speak English, you know, her husband
15 spoke perfect English, when he was more than once,
16 you know, up at the nurse's station being like
17 what you are doing, what are you doing, my wife is
18 dying, you're not doing anything. You know, is
19 she going to die, all of these things.

20 And she had been booked for surgery
21 two or three times and the surgery had never
22 happened. And sometimes -- I mean, it's not that
23 there was a very good excuse. There was always,
24 you know, something else going on.

25 So the first time she was booked, she

1 was booked as an add on. They ran too late. They
2 couldn't get her done. It happens all the time.
3 It happens to us on a regular basis all the time.
4 So she was scheduled for the next day.

5 So the next day there was a sign out
6 and it said okay, today's the day, you know,
7 everybody's on board. She's finally getting her
8 surgery. We expect improvement. And then that
9 also didn't happen.

10 From my understanding -- and I only
11 found this out actually speaking with our GI
12 consultant, because, again, I was, myself and
13 other members on the team, unable to get ahold of
14 surgery.

15 But we found out that GI had
16 basically kind of cut them off at the knees as we
17 were giving the patient Vaxzane (phonetic), no,
18 no, no, she needs an ERCP.

19 So the GI consultant called me and
20 said, yes, you know, we stopped her surgery, we're
21 initiating ERCP. The plan is for her -- to get
22 her ERCP, stay under sedation, be transferred over
23 and then continue the surgery as previously
24 scheduled, and so I was like, okay, fine.

25 And then it was much to my chagrin

1 when I found her back in her room around about an
2 hour later with no surgery and no idea why she
3 didn't have that surgery.

4 And that is when I called the general
5 surgery resident, and after about two hours, I was
6 finally able to get ahold of him, and I flew off
7 the handle. It was inappropriate and
8 unacceptable, but I just felt like nobody was
9 paying attention to that patient and she was very,
10 very sick and nobody was taking the time to then
11 explain to anybody as part of her primary team,
12 let alone the patient herself or her husband why
13 things weren't going as we told them that they
14 were going to go.

15 And so after that outburst, I
16 apologized to the chief resident, I think the
17 attending was also there, also the other people
18 involved.

19 I called Dr. Glover, who was the MFM
20 on that day, who generally takes care of these
21 patients with us, and I told her that I had lost
22 my cool and that I felt like it would be best if I
23 stepped away in terms of direct communication.

24 So I did. And then I told, you know,
25 my resident team what happened and I apologized to

1 them that they were likely going to have a harder
2 time trying to kind of get things done because of
3 what I had done.

4 Obviously I was still involved in her
5 care and I was still taking calls on her, but I
6 asked my junior residents to take up that role
7 again of communicating with the other teams
8 because it felt unprofessional in my mind for me
9 to continue to do that. So that was that patient.

10 So essentially that was a Friday and
11 I wasn't on call that weekend. So that was just
12 kind of the natural end to my involvement with
13 that patient.

14 DR. POZNANSKI: I need to interrupt
15 you just a minute. If you were to complete the
16 program and become an acting clinician and you, I
17 think your words, lose your cool, who's going to
18 take care of the patient then?

19 DR. MARES: I appreciate that nobody
20 else could do that. Well, sometimes somebody can,
21 but likely that responsibility will not be there
22 and I won't always have co-residents who can do
23 those things and pick up my slack, so I do
24 appreciate that.

25 DR. POZNANSKI: Okay.

1 DR. PAINTER: Other questions for Dr.
2 Mares?

3 DR. POZNANSKI: I would like you to
4 elaborate on the patient whose mother was being
5 held off campus for trespass after yielding a
6 knife. I think that would be helpful for you to
7 cover that for us to better understand it, because
8 that was another accusatory thing.

9 DR. MARES: Right. So with that
10 patient, I was the chief covering OB days.
11 There's only one chief on consult because that
12 program is a little short.

13 And I was vaguely familiar with the
14 patient because she was admitted the day prior,
15 and I had also been getting updates through the
16 night chief about kind of what her status had
17 been.

18 Her obstetrical course had always
19 been, you know, more or less, truly unremarkable,
20 but she had multiple, for lack of a better word,
21 just kind of, you know, mental health issues that
22 were providing barriers to her care.

23 I was told by nursing staff that they
24 felt very uncomfortable taking care of her. We
25 had nurses who were, you know, crying at the

1 bedside dealing with this patient and who had
2 been, you know, kind of removed from that case.

3 She had been -- my junior residents
4 had been working well with her, so she was a term
5 patient. Again, the responsibility of my first
6 and third year. The first year was not involved
7 in her care. I'm not even sure why that was, but
8 she was being followed by the second year and the
9 third year, who both knew her and both had a
10 relationship with her.

11 And then I came in the next morning
12 and I also received kind of a very quick sign out
13 from the night chief before we went to our sign
14 out about the events that had unfolded that night.

15 The patient had become increasingly
16 combative, both verbally and physically. She had
17 threatened to multiple members of the staff,
18 including, you know, my co-chief and nurses that
19 she was planning on breaking the neck of the
20 intern who was taking care of her that night if
21 she ever came back in that room.

22 So the intern was taken off of that
23 case. And that at one point in the night the
24 patient's mother had come in with a knife to the
25 hospital premises and was removed by security.

1 So it seemed very clear to me that
2 not only were they making a lot of these threats,
3 but they also had some intention on carrying
4 through some of these threats.

5 So when the patient was presented at
6 our sign out, I said I don't feel comfortable
7 taking part in this C-section.

8 You know, I've never met this patient
9 face to face. She has a well-established
10 relationship with both my second and third year,
11 who are both perfectly competent of doing a
12 primary Cesarean section for a non-emergent
13 reason.

14 I don't recall ever using expletives,
15 although that is what Dr. Yaklic said. So if I
16 did, I am sorry. That was not my intention.

17 My intention was just to say that I
18 didn't feel comfortable doing that, because in the
19 research that I've done about these patients, I
20 actually did my grand rounds on dealing with
21 peripartum mood disorders.

22 Dealing with a psychotic patient is
23 actually an entire chapter in obstetrical books
24 under obstetrical emergencies.

25 And the number one thing that it says

1 is to keep them in situations and with people that
2 they feel comfortable with. So I felt that going
3 in there as a person that didn't know them,
4 that -- you know, I had no face value with them,
5 it felt unnecessary and almost wrong, when
6 literally the people sitting next to me are the
7 second and third year who were taking care of her
8 the day before and who had already established a
9 relationship with them, and who, from my asking
10 them, still felt comfortable participating in her
11 care, because I did ask and I told them what
12 happened that night. I said do you still feel
13 comfortable participating in her care, and they
14 said yes.

15 And so that was the plan. It was a
16 Tuesday or Thursday morning, so our baseline chief
17 is generally not on the floor for Cesarean
18 sections, except in emergency situations because
19 they're supposed to be done in our high risk
20 clinic.

21 So that surgery and generally any
22 non-urgent Cesarean section is generally performed
23 by the second year who is running the entire board
24 that morning, as it were, and then the attending.

25 And so I believe that's what

1 happened, although I don't know. And, again, this
2 situation was also never discussed with me until I
3 was being fired for it.

4 So I just wish that if people had
5 such a level of concern about how I acted, that
6 they would have spoken with me, and I appreciate
7 that I haven't made it easy for other people to
8 approach me, but I still think that they should
9 probably have tried, because in my mind,
10 unfortunately, we have patients like this every
11 day, and some of them, you know, like I walk in,
12 you know, everything goes well, you know, I'm
13 going to get past it.

14 And in other situations like this, it
15 can be more difficult, but I still have all of
16 these other patients to care for, and so I move
17 on. You know, I acknowledge the situation
18 happened. I think about what happened. I try to
19 make steps that I can do to make sure that
20 something like that doesn't happen again, and then
21 I just move on with my day, and then I'm never
22 told about it until it's clearly already bubbled
23 over to a head.

24 DR. YAKLIC: Can I stop you for one
25 second? It was the 21st, it was a Friday, it

1 wasn't a Thursday.

2 DR. MARES: Okay.

3 DR. YAKLIC: You -- if you would have
4 handled it in the call night, it wouldn't have
5 been an incident, but you didn't. You emotionally
6 blew up. Insisted you were not caring for the
7 patient.

8 You didn't talk with the junior
9 residents. Your junior resident wasn't involved
10 in the case, other than the intern who had not
11 submitted.

12 It wasn't like you sat there and said
13 do you have a relationship with these patients, I
14 need you, why won't you take care of it? That
15 wasn't what you did, Jackie. You blew up and you
16 refused to care for her.

17 DR. MARES: The second year --

18 DR. YAKLIC: That is a different
19 situation.

20 DR. MARES: And as you're saying,
21 yes, I agree, but the second year and third year
22 were sitting next to me who took care of her the
23 day before and who knew that patient.

24 DR. YAKLIC: She wasn't -- but the
25 point is you're saying you didn't have a

1 relationship with the patient, that's why you
2 didn't want to care for her? Your point was you
3 did have a relationship with the patient and her
4 mother had been threatening you. So you're
5 contradicting your own reason for not wanting to
6 speak with her.

7 DR. MARES: No, I didn't say that.
8 The patient was never threatening to me. This was
9 something that happened overnight with a different
10 team and I was --

11 DR. YAKLIC: But you had cared for
12 the patient the day before. You had been involved
13 in her care.

14 DR. MARES: I was the chief on call
15 the day before. I never formally met her. I
16 was --

17 DR. YAKLIC: You had a relationship
18 with her.

19 (Thereupon, the court reporter
20 interrupted the proceedings.)

21 DR. YAKLIC: You had a relationship
22 with her.

23 DR. PAINTER: Just one at a time.

24 DR. TALBOT: Can I say one thing as
25 well about the -- a couple of the accusations

1 about that this was never talked to me until I was
2 fired?

3 I talked to Dr. Mares on the floor.
4 I sent her a text. I said I need to meet with you
5 today, it's very important, and I reviewed it,
6 what I had been given by the CCC.

7 It was not like I was intending the
8 CCC -- I knew this was coming from the CCC. This
9 did catch me a little bit by surprise, not
10 completely, but the overwhelming urgency of it.

11 So I brought Dr. Mares into my office
12 with my coordinator, and there is my account from
13 that on the 4th and her account. Dr. -- or Ty
14 Gebhard, her summary as -- as she witnessed the
15 same conversation.

16 I had said at that point that I am
17 doing my due diligence. I am unbiased. I'm
18 trying to get all information I can to help me
19 make this decision.

20 And that's when she said, well, this
21 decision has already been made kind of thing.
22 It's all in there from -- in her file from that --
23 this day.

24 And so I don't think that's fair that
25 this was never discussed until she was fired. I

1 think, if anything, this was just another example
2 of an unprofessional response to I'm throwing you
3 this lifeline.

4 If you want to finish, you want to
5 get this -- through this year, you tell me all
6 of the -- all of what you told today. This was
7 not the Jackie that I get.

8 And so maybe I'm not the same person
9 as Dr. Croom or Dr. Glover that can learn -- know
10 her on that same level, but I can certainly
11 advocate for her, as I did at the start of when I
12 became -- when it was clear I was going to become
13 the program director.

14 And I said on the 5th when -- that is
15 when I had made the decision, and that is when Dr.
16 Yaklic met when I -- and I said that again to her.
17 I said I really felt I gave you a fresh start and
18 a clean slate.

19 So I think that is a little bit
20 unfair statement about this that nobody talked to
21 me until I was fired.

22 DR. CROOM: Can I comment on one
23 thing? I agree with you, the actual firing did
24 not take place until that meeting you just
25 described, and I think that was on a Friday, if

1 I'm not mistaken.

2 DR. TALBOT: Right.

3 DR. CROOM: I got a call Wednesday
4 afternoon from Dave McKenna who told me the
5 decision of the committee. I had no idea they
6 were meeting, I had no input into that, and I was
7 told by Dave McKenna, I think it's important if
8 you call Ted, okay?

9 I tried to reach you that day and
10 wasn't able to. I was out of town the next day,
11 but we touched base --

12 DR. TALBOT: We touched base twice.

13 DR. CROOM: Yeah, on Friday.

14 DR. TALBOT: On Friday we touched
15 base and also I believe late in the day on
16 Thursday. You wanted to know when I was off
17 seeing patients and when I was there.

18 DR. CROOM: Right. And I can tell
19 you the feeling that I had, based on what Dave
20 said, and the way I was almost begging you to give
21 her some sort of second chance, I had the feeling
22 that it was a decision already made. I mean, that
23 was the impression I had from that conversation,
24 okay?

25 I knew that officially you could

1 disagree with the -- the committee, and you told
2 me that, but you also shared with me that you
3 really were put under some pressure. You were
4 told by some of the committee, are you going to
5 follow through with our recommendation? Are we
6 going to continue to behave like we have in the
7 past?

8 And so I felt you were -- you were
9 put under some -- what I thought was very unfair
10 pressure by some of the committee members, and I
11 just had the feeling that it was kind of a done
12 deal, and I'm not Jackie, I haven't experienced
13 what Jackie has felt, but the fact that she walked
14 in there and felt that way, you know, I'm not
15 surprised by that.

16 DR. YAKLIC: The CCC clearly had made
17 a recommendation. Their decision was made.

18 DR. CROOM. Right.

19 DR. YAKLIC: And it was sent to the
20 program director.

21 DR. CROOM: Correct.

22 DR. YAKLIC: I know that at least
23 twice during that time period, we also spoke with
24 Dr. Painter and others in school administration to
25 discuss the options. It was not a done deal.

1 And Ted really was looking for her to
2 say, I understand. He didn't get it. He got a
3 refusal to even speak. Three times account of
4 their meeting. There was a third party sitting
5 there. She refused to speak.

6 She was given the opportunity to --
7 for that input, and, unfortunately, reacted in the
8 way she always reacts to these stressful,
9 difficult situations.

10 DR. POZNANSKI: Jackie, could you --

11 DR. YAKLIC: She turned around and
12 stormed out.

13 (Thereupon, the court reporter
14 interrupted the proceedings.)

15 DR. POZNANSKI: I asked Jackie if she
16 could comment on that meeting in terms of her
17 response.

18 DR. MARES: I knew going into the
19 meeting that it wasn't going to be a good one,
20 because as Dr. Talbot had mentioned, he just
21 texted me in the middle of my working day on
22 Thursday like we need to meet.

23 Unfortunately, there weren't a lot of
24 cases scheduled that day, so I said fine, and we
25 set up a time and we went over there, and Ty was

1 there, and Ty is -- I don't know what her title
2 is. I think she's like a residency coordinator,
3 but in each of the situations previously with my
4 warning, my probation, the residency coordinator,
5 who was not previously Ty, but nobody's been
6 there.

7 So I knew walking into it that it was
8 something bad, just by the fact that she was
9 there, and previously when I met with Dr. Talbot
10 or other people, you know, nobody else would be
11 there.

12 So I did feel very offensive by that,
13 and he started out by just talking about the
14 clinical competency committee, and like I already
15 knew it was something bad, and so I didn't know
16 why he was like rambling on about this clinical
17 competency committee. It didn't like mean
18 anything to me, and I wasn't really listening to
19 what he was saying.

20 I wanted him to just say what he had
21 clearly called me in to say. And then he told me,
22 and I did feel very like taken aback, because the
23 last time I had met with Dr. Talbot, the decision
24 was that I was doing better, I was coming off of
25 probation, I was going to be able to work, you

1 know, abroad during my rotation, and obviously I
2 knew that these other situations had happened,
3 but, again, nobody had approached me about them
4 otherwise, and so I didn't really have like a
5 major cause for concern that that was exactly what
6 was going on.

7 And I became very irritated, because
8 it just -- to me, it just felt like it was coming
9 out of nowhere.

10 Like the last meeting that we had
11 had, I was coming off of probation.

12 DR. GLOVER: At the very end of
13 August?

14 DR. MARES: Right. So, yeah, that's
15 how I felt. And I remember trying to -- like he
16 didn't even ask what I thought had happened in
17 those situations. He just told me what, you know,
18 the accounts were.

19 So like the e-mail from Dr. Kindig.
20 He told me that, you know, Dr. Yaklic had a
21 problem with that thing.

22 And I said it seems very clear to me
23 that you've already made up your mind, you know,
24 and like you never even asked me what I thought
25 or, you know, what my perspective was in those

1 situations. And he said that, you know, clearly
2 there were just so many situations and that like I
3 was the common denominator, so there was a
4 problem.

5 And like my perspective on what
6 happened wasn't overly relevant because it still
7 happened and it was still a problem.

8 So I didn't really feel like sharing.
9 So I left and I asked to leave and I then texted
10 Dr. Talbot, I don't know, maybe about 15 minutes
11 later and said sorry, for just kind of leaving
12 that way.

13 He had mentioned that he wanted me to
14 go to a meeting with all of these people that I
15 didn't know, and I said I want to go to that
16 meeting, I just don't want to go today. And he
17 said fine, and that we'd find a time to meet on
18 Friday.

19 So I returned to, you know, the
20 things I was doing on Thursday, and, you know, I
21 did my duties and things on Friday until that
22 meeting, at which point I thought we were going to
23 talk about options that I had, because Dr. Talbot
24 had mentioned that there were options, but instead
25 I was just dismissed from the program. So that's

1 my recount of what happened. I can't speak for
2 obviously what they thought happened, but that's
3 my perspective.

4 DR. BARNEY: Help me understand. In
5 August you said you met and you were told you were
6 coming off of probation?

7 DR. MARES: (Witness nodding head up
8 and down.)

9 DR. BARNEY: Like effective what date
10 you would be off of probation?

11 DR. MARES: They said by December --

12 DR. YAKLIC: (Inaudible.)

13 DR. MARES: They said by the end of
14 the year.

15 (Thereupon, the court reporter
16 interrupted the proceedings.)

17 DR. PAINTER: Hold on.

18 DR. TALBOT: Well, there's an August
19 29th --

20 (Thereupon, the court reporter
21 interrupted the proceedings.)

22 DR. PAINTER: One at a time. We
23 understand your challenge here.

24 DR. BARNEY: So I'm just seeking
25 clarification as to your understanding of what

1 happened in August regarding your probation
2 status.

3 DR. POZNANSKI: I'll just add -- I'll
4 add onto that question, it was your interpretation
5 that you were coming off of probation. Was it
6 your interpretation that that was a set deal or
7 did you have certain things that you had to
8 complete in order to make that happen?

9 DR. GLOVER: If she can pull that up,
10 it's described in the letter.

11 DR. POZNANSKI: I understand. I've
12 seen it in one of the previous documents. I want
13 to know what your interpretation was.

14 DR. MARES: I wasn't told that there
15 was anything else specifically that I had to do
16 between now and then. I was just told that they
17 were going to be taking me off of probation by the
18 end of the year, like in December, and I said
19 okay.

20 I didn't -- in retrospect, I should
21 have asked, you know, why December, what's
22 supposed to happen between now and then? But I
23 didn't. I just said okay and that was it.

24 DR. BARNEY: Was there a letter?

25 DR. TALBOT: There is a letter.

1 (Thereupon, several people in the
2 room were having a discussion.)

3 DR. BARNEY: Is it in the resident
4 file or is this the other file?

5 DR. TALBOT: It's in the resident
6 file.

7 DR. BARNEY: The other question,
8 while we're hunting for that, Dr. Mares, is maybe
9 I don't completely understand how the service
10 works on OB-GYN, but my understanding from being
11 an educator in a teaching service is that in team
12 care, the attending is always -- the buck stops at
13 the attending, and ideally you're in a training
14 environment, so the attending is the responsible
15 person. Is that not the way it happens on OB-GYN?
16 Every patient has an attending assigned to them.

17 DR. MARES: Right.

18 DR. BARNEY: So there's some
19 attending's name on the chart who ultimately, if
20 there's a conflict or a question, some interaction
21 with the attending would be the last step in a
22 problem?

23 DR. MARES: Correct.

24 DR. BARNEY: So did you have -- in
25 these experiences, did you have a sense that you

1 were not able to talk to the attendings when there
2 were issues where you felt like I'm -- I shouldn't
3 be involved in this case anymore, I should talk to
4 my attending and just say, hey, this is -- you
5 know, this is going south and I think for
6 everybody's benefit, I should step back and let
7 these other residents be involved? Is that not a
8 process that normally happens?

9 DR. MARES: I -- I'm not sure I can
10 really answer your question. I think from, you
11 know, me and like what you're referencing to, you
12 know, like I usually did tell my attending when
13 these things happened.

14 So, I mean, I told Dr. Glover about
15 the one case, and it was absolutely my intention
16 to speak with Dr. Talbot about the other case,
17 although that just wasn't necessary because of how
18 that panned out.

19 We do take a very authoritative
20 role, I guess, as a chief resident. They're
21 viewed as our patients, and the attending is
22 always there, but the -- they're there in an
23 observer role. Like you call them and you tell
24 them what the plan is, and that's that
25 expectation.

1 So, I mean, it wasn't a surprise to
2 me that, you know, as they were initiating the
3 chain, that they called me first before calling
4 somebody else. That is how things are done in our
5 program, and I think that we would all say that we
6 feel the need to be ready and have things done,
7 you know, so that by the time we go to the
8 attendings --

9 DR. BARNEY: Okay.

10 DR. YAKLIC: I will say I think our
11 service is a little bit different than surgery.
12 The patient is really your patient. The residents
13 are involved in our service, especially our OB
14 staff service and emergency staff service.

15 It's the -- we consider that the
16 chief section. We're rotating on their service,
17 they're not rotating on our service, so you're
18 always going to have that attending as your backup
19 person, but there is always an attending.

20 I mean, we consider to be practicing
21 like the ACGME says. Independently under
22 supervision. There's always supervision. There's
23 always that person there to ask, but the
24 expectation is they should take ownership of their
25 patient.

1 It is just like a private practice,
2 and, you know, and they're treated as if
3 they're -- you're the chief. And the expectation
4 is they should really be caring for that patient.
5 And as an attending, you don't refuse to continue
6 caring for your patient.

7 I think that's the challenge. And if
8 you do get to that situation, you need to discuss
9 it in a professional manner.

10 DR. GLOVER: May I make a comment as
11 Jackie's advisor? As an attending physician, and
12 this is my practice, when I have a resident who's
13 having a meltdown or telling me they're
14 uncomfortable, I try to understand what they're
15 trying to tell me.

16 I hope that when Jackie told you that
17 she was uncomfortable dealing with a patient who's
18 acutely psychotic, for good --

19 (Thereupon, Dr. Yaklic interrupted
20 the proceedings.)

21 (Thereupon, the court reporter
22 interrupted the proceedings.)

23 DR. GLOVER: -- for good clinical
24 explanation for the patient's benefit, but I hope
25 you also inquired about the team's safety. How do

1 you feel? Is anyone physically threatened?

2 Because I know you've never been the
3 small woman in the room, Jerry, you haven't.

4 And there's a reason I got myself
5 physically beat on two to three times a week for
6 several years to get a black belt so I could
7 physically be more capable in this place.

8 So I hope, I hope that -- despite our
9 greatest frustrations of a resident who we're
10 perceiving as belligerent and emotional, I hope
11 we're still thinking about their safety.

12 DR. YAKLIC: And I'm not referring to
13 that case in particular.

14 DR. GLOVER: I am.

15 DR. YAKLIC: Okay? That's fine. In
16 that situation, I would have been more than happy
17 to have that discussion with the chief resident
18 because --

19 DR. GLOVER: But did you initiate
20 it?

21 DR. PAINTER: One at a time.

22 DR. GLOVER: Sorry. Sorry.

23 DR. YAKLIC: Because she flew off the
24 handle, was acting unprofessional, and at that
25 point, in all honesty, my feeling was -- and I

1 wish I would have brought a bigger attention to it
2 sitting here now. I've said that to Ted three
3 times; however, at that time, to make a bigger
4 deal of it would have been to point out the
5 unprofessionalism either further to the junior
6 residents, nurses and others in the room.

7 It -- it caught me completely by
8 surprise. It was a completely by surprise
9 approach. I -- there's not a resident in this
10 program that will tell you at any given time, you
11 tell me, will you please do this C-section for me,
12 the answer is always yes.

13 It drives you crazy pacing around
14 with your hands behind your back because you're
15 not doing the surgery. I'm always happy to help
16 out in any situation, whether it's because
17 someone's uncomfortable caring for this particular
18 patient, it's going to be a particularly difficult
19 case, the service is overflowing and busy.

20 That wasn't the response. It had
21 nothing to do with her not caring for that
22 patient. It was the unprofessional nature in
23 which she dismissively (sic) said, I'm not dealing
24 with this, and basically stormed off. That was
25 the problem.

1 And even when I relayed that message
2 to Ted, I mean, fortunately I had surgery that
3 afternoon, I was leaving town for vacation, I was
4 looking for a private moment to talk to Jackie
5 about it and it never came up, unfortunately,
6 before I left.

7 But I did call Ted and relayed it to
8 him, and even when I said it, I'm like, you know,
9 I know she's on probation, I don't personally
10 think this is a big enough issue to change
11 anything, but you need to be made aware of it,
12 okay?

13 No, that -- I -- that episode in
14 isolation would not have been anything that would
15 have prompted dismissal, okay?

16 DR. POZNANSKI: Do you happen to know
17 who the residents or junior residents were that
18 were on that particular case?

19 DR. YAKLIC: Yeah, you know who it
20 was. Who were your residents?

21 DR. MARES: Dr. Brant, Dr. Paulette,
22 Dr. Hancox and Dr. Candea.

23 DR. POZNANSKI: And when you say the
24 second and third year were comfortable doing
25 that --

1 DR. MARES: That was Dr. Paulette and
2 Dr. Durrant. And I would also just like to say
3 that I truly, from my perspective, don't feel that
4 I was acting completely irrational in saying I
5 didn't feel comfortable doing that.

6 I also did not feel like I was flying
7 off the handle. I said that I didn't feel
8 comfortable doing it, and you said nothing, and we
9 moved on and finished sign out. I didn't abruptly
10 leave.

11 We continued with patient care, as we
12 always do, and then I went on with my business as
13 I always do.

14 DR. GLOVER: This patient and her
15 family were so difficult. It did not stop with
16 this case. Her younger sister, who is a minor,
17 soon thereafter had a scheduled elective
18 C-section.

19 I was the attending on that day, and
20 there was the whole thing again with the mom who
21 had been -- who had trespassed and bearing the
22 knife and she was acting out for campus police
23 that day, and I had the father there, and he
24 wouldn't consent to his minor daughter having the
25 surgery, and I was supposed to supervise, unless

1 his wife could be there.

2 And it this whole -- we spent the
3 whole morning, just the whole morning, delaying
4 the surgery because I couldn't get consent because
5 this family was being so disruptive to the point
6 where I said, maybe we should just reschedule
7 this, it's not going well. This is how difficult
8 they were.

9 DR. TALBOT: Just one more --

10 DR. PAINTER: We're going to get
11 kicked out of here at noon and we can go across
12 the room if we need to.

13 DR. TALBOT: No, that's the only
14 question about probation. It says in there we
15 discussed her coming off probation in the next
16 three months if she continues to progress as she
17 has been.

18 And then on the bottom it is, we'll
19 continue to meet monthly regarding her progress.
20 It is my plan if she continues to show
21 improvement, she will be taken off probation by
22 the middle of December, the reasons why and if I
23 could help her in any way.

24 So it was contingent on that we
25 continued to see improvement, and the CCC, when

1 they met again, these issues were discussed.
2 There was -- there's also several other residents
3 that are discussed. So there -- we spent at least
4 a half an hour or more on Dr. Mares, and a lot of
5 the conversation did address these issues, but not
6 with every one did they say, well, what's her side
7 of the story to justify this.

8 There was a continual pattern of
9 unprofessional behavior such that they deemed that
10 she would not come off of probation. That was the
11 take home message from all this.

12 DR. CROOM: Ted, I mean --

13 DR. TALBOT: The minutes are there,
14 too. I'm sorry.

15 DR. CROOM: No, no, no, what I'm
16 saying is, the questions that this panel has asked
17 are primarily what was Dr. Mares' side of the
18 story, and I think it would have been helpful if
19 the CCC had had some input prior to making that
20 decision. That was never done.

21 DR. YAKLIC: Are you suggesting that
22 you think she should have been allowed to come and
23 talk to the CCC?

24 DR. CROOM: No, no, someone should
25 have presented that for her. Her mentor or

1 someone should have presented that.

2 DR. YAKLIC: Dave was her former
3 mentor.

4 DR. CROOM: That's not what I said.
5 Someone should have presented her side and it was
6 never presented. I mean, that's not her fault.

7 DR. TALBOT: Well, we're getting her
8 side today. It wasn't --

9 DR. CROOM: Well, I understand that.

10 DR. TALBOT: It wasn't --

11 (Thereupon, the court reporter
12 interrupted the proceedings.)

13 DR. BARNEY: One at a time.

14 DR. PAINTER: One at a time.

15 DR. TALBOT: I think we tried to ask
16 for that, the attendings that were involved and
17 approached her and never could get it. We're
18 getting today much more than we ever did. So
19 they --

20 DR. POZNANSKI: Why do you think that
21 is? I mean, you made a comment earlier that this
22 is not the Jackie you had before.

23 DR. YAKLIC: Well, the first time I
24 heard Jackie say --

25 DR. POZNANSKI: What's changed?

1 DR. YAKLIC: The first time I heard
2 Jackie say she needed to finish this program and
3 cared about finishing this program was the day she
4 got her dismissal letter. I mean, I guess I'll
5 ask the question, you know, rhetorically to Jackie
6 and she can answer if she'd like.

7 When she was given a formal letter of
8 warning and then put on probation, did she not
9 seriously feel that she was at risk of not
10 completing the program enough to change her
11 behavior and make that full effort.

12 You said you sought -- sought
13 counseling since being dismissed. Did you
14 consider doing it prior to that? Did you realize
15 your behavior was a problem?

16 You were told on numerous occasions
17 in all those letters that you were risking
18 dismissal from the program. Why didn't you care
19 about it? I mean, I really wish -- I want to
20 know. Why didn't you care about it until you were
21 dismissed?

22 Because I -- we -- I personally asked
23 you, mentioned in the hall a couple times
24 informally, and said you really need to graduate.
25 You really need to sit for your Boards. You

1 really need to be a Board certified OB-GYN even if
2 you choose to walk away after that.

3 I wanted you to succeed and I wanted
4 you to care enough to succeed, and you didn't
5 until we dismissed you, and I wish you would have
6 done something earlier.

7 And I did speak to you on several
8 occasions, and I'm sorry if I didn't do it enough.

9 I agree with Melanie, we failed you
10 okay? But you failed us, too. We asked you to
11 improve and you didn't do it. You didn't take it
12 seriously until you were dismissed.

13 DR. POZNANSKI: I would like to hear
14 Jackie's response to that.

15 DR. MARES: I -- I personally always
16 felt very dedicated to this program, and I think
17 that you'll see that in the letters that, you
18 know, my co-residents wrote on my behalf, and
19 regardless of what I plan to do afterwards, I
20 always planned on, you know, putting in 100
21 percent to finish this program and to do it to the
22 best of my ability.

23 And I know that I -- I knew that I
24 needed, you know, to continue to grow and improve
25 in a lot of areas, and I feel like I made

1 concerted steps in the best way that I knew how to
2 do that.

3 I did seek counseling earlier in my
4 third year, which I did not think was relevant to
5 previously disclose you, but I didn't do that
6 because I did appreciate the gravity of the
7 situation, but at that point in time, it just -- I
8 kind of felt just so broken down that it didn't
9 really matter like what else I did.

10 I was just going to continuously
11 disappoint everybody. So I just tried to, you
12 know, go through each day with each thing that was
13 presented, and, you know, as I continued to do
14 that, my perspective changed and I found something
15 that I became very passionate about that ideally I
16 would like to pursue, you know, if I were to
17 graduate, but I just felt like I couldn't ever
18 truly talk to somebody about, you know, why I
19 wasn't going to like take my Boards or why I
20 wasn't going to practice.

21 I don't feel like people really
22 asked, and if they did, it was to ask me like, you
23 know, how are you doing today; fine. You know,
24 like, so why aren't you, you know -- like, oh,
25 like talking to me across the OR table like so why

1 aren't you taking your Boards? I'm not going to
2 talk to you across the OR table about, you know,
3 why I'm not taking my Boards, so, yeah, I just --
4 that's why.

5 DR. POZNANSKI: It seems to me that
6 you've been a big patient advocate and that you
7 enjoy clinical care. Why aren't you taking your
8 Boards? What is the decision to step away from
9 that going forward?

10 DR. MARES: So from my perspective,
11 you know, I was a problem resident. I had a
12 warning letter. I was on probation. I clearly
13 wasn't performing to the standards of my residency
14 program. I didn't feel like anybody would hire
15 me. I wouldn't hire me.

16 So I felt like it would probably be
17 better if I just tried to find something else to
18 do. That's why.

19 DR. POZNANSKI: Do you want to be a
20 clinician?

21 DR. MARES: Yes, I do.

22 DR. GLOVER: Why don't you offer to
23 them a patient population that has really drawn
24 your affection that you were alluding to wanting
25 to take care of other patients?

1 DR. MARES: We are in the opioid
2 capital of the United States and we deal with a
3 lot of addicted mothers and addicted women in
4 general, and our program has taken a specific
5 interest in helping these women, and the residents
6 have been invited into that care, and I just -- it
7 was like the one patient population that I work
8 with where I know a lot of other people don't
9 enjoy working in that setting, but it's just -- I
10 didn't feel like it was work.

11 It didn't feel hard. It felt really
12 easy, and, so, you know, I'd like to continue
13 working with them theoretically in substance abuse
14 and disorders, and I was recently told that there
15 was even a fellowship in addiction, which I didn't
16 know about until a few months ago. So, yeah.

17 DR. CROOM: Jackie is working with me
18 in my clinic for opioid addicted moms, and you
19 know, I was never asked about this reoccurring
20 thing about her not taking the Boards.

21 My conversation made it very clear,
22 Jackie, in order to do a fellowship in addiction
23 medicine, you have to be Boarded. And my
24 understanding, the conversations we had, was that
25 was the direction she was headed in, to get

1 Boarded in OB-GYN, but she would be practicing
2 addiction medicine. To get into a fellowship, you
3 have to be Boarded, and I never got the
4 opportunity to share any of that.

5 The other thing I want to make -- I
6 mean, Jerry, it -- it -- I was glad that you
7 shared that you thought we failed Jackie.

8 DR. YAKLIC: We did.

9 DR. CROOM: Because, I mean,
10 Melanie's compelling. I mean, you know, I didn't
11 realize the depths until I got to know Jackie
12 fairly well, but not to the degree of everything
13 that she shared with us and the big picture that
14 we all missed, and the fact that we both played a
15 part in this, I find it disturbing that only one
16 person is receiving consequences from that.

17 DR. YAKLIC: Nobody -- the program
18 does not take pleasure in discharging a resident,
19 okay? And anybody who feels that the program
20 director and the chair being here at this
21 proceeding instead of interviewing next year's
22 incoming interns and that doesn't have a
23 consequence for the program, I think that's an
24 unfair statement, okay?

25 But this -- this was a very difficult

1 decision for Ted taking over as the new PD. This
2 was a very difficult decision for the faculty.
3 This was a very difficult decision for the
4 clinical competency committee.

5 You know, I'll talk about additional
6 consequences. You know, we had several other
7 residents. One of them is a former grad, so it's
8 not all current residents.

9 I can tell you at least one of the
10 residents who wrote a letter and another one of
11 the chiefs were in my office with that other chief
12 crying because they were coerced, they felt, to
13 write letters on her behalf by you.

14 I'm not saying that the letters that
15 were written weren't intentional or weren't
16 indicative of what their feelings for Jackie are,
17 there's clearly support, but it damages -- this
18 just clearly damages our program.

19 Nobody -- the easy thing to do would
20 have been to graduate Jackie, and that's
21 unfortunately in some cases in the past what we've
22 done, but our prior mistakes don't make future
23 mistakes correct either, okay?

24 I've heard from several people, we've
25 graduated worse residents. You know, I don't say

1 I'm going to agree or disagree, but that doesn't
2 mean we should continue to do that.

3 We are trying to improve this
4 program. Trying to improve our standards. I made
5 efforts. You know, I -- too many jobs. I haven't
6 been around clinically as much as I would like to
7 recently.

8 I clearly feel we failed Jackie, I
9 really do, but, you know, you can't help somebody
10 who isn't willing to help themselves, and we've
11 offered on many occasions the opportunity to help.

12 I can tell you personally, several
13 residents in our program that have had depression
14 and other issues that have asked me, how do I get
15 a confidential counseling? Military residents,
16 how do I do this without the military finding out?

17 We found people for them. I can't
18 help you if you don't ask me to help you.

19 And, I mean, to Melanie's point, you
20 know, well, maybe we should have mandated a
21 psychiatric evaluation.

22 Would that have been less damaging to
23 somebody's career than seeking confidential
24 counseling? I -- I don't think that anybody ever
25 felt that there was a psychiatric condition.

1 DR. GLOVER: Jerry, I never said
2 that.

3 DR. YAKLIC: Yeah, you did, because I
4 wrote it down when you said it.

5 DR. GLOVER: I did not say mandates.

6 DR. TALBOT: Dr. Croom said that to
7 me in the phone calls, and I have that in my --

8 DR. CROOM: I asked is that something
9 that could be mandated.

10 DR. TALBOT: You can't. Well, no, it
11 can't because I've got here -- this is from
12 residents remediation, probation and dismissal.
13 It's in the pathology letter, and it says, medical
14 or mental health issues that affect resident
15 performance are also grounds for remediation,
16 probation or dismissal.

17 A resident cannot be forced to seek
18 counseling or therapy, and the program director
19 should not attempt to diagnose the perceived
20 medical or mental issue for the resident or insist
21 that a resident seek specific care; however, the
22 program can expect that the resident take any
23 necessary steps to address medical or mental
24 health issues and produce a fit for duty letter.

25 This was done at the letter of

1 warning. It was done again at the five day
2 absences the month later. It was done on formal
3 probation and it was done with my initial April
4 letter.

5 So I don't know more what -- like
6 he said, what more we could do on that aspect.

7 DR. GLOVER: You could have gotten to
8 know her and understood how lonely she was and how
9 self-deprecating she was every time her failures
10 were pointed out to her and how --

11 DR. YAKLIC: I don't know how we
12 force someone to allow us to get to know them.

13 DR. GLOVER: You can't force it.

14 DR. YAKLIC: I guess that's --

15 DR. GLOVER: You have to foster an
16 environment in which they allow themselves to be
17 known.

18 DR. YAKLIC: All I'll say is in the
19 last three years in the time that Jackie's been
20 here, my door has always been open, and many other
21 residents have come in. Several of them have
22 asked for help in obtaining counseling and other
23 things.

24 Again, I'm not claiming I'm perfect,
25 and we all go through periods of growth, but I

1 don't know what else I could have done.

2 DR. GLOVER: It's -- please, just
3 what I'm trying to say is it's very different to
4 ask for help under the circumstance of your own
5 volition. It's --

6 DR. YAKLIC: Okay. I understand
7 that. Melanie, did you identify that there was --
8 you have a close relationship. You knew that
9 there were these concerns. Did you bring them to
10 myself, Dr. Talbot, Dr. Galloway?

11 DR. GLOVER: I developed my
12 relationship with Jackie in the --

13 DR. YAKLIC: Did you advise her to
14 come and talk to one of us?

15 DR. GLOVER: So she --
16 (Thereupon, the court reporter
17 interrupted the proceedings.)

18 DR. PAINTER: Hold on.

19 DR. YAKLIC: Prior?

20 DR. GLOVER: I did not know her that
21 way. I did not know -- I did not know she was on
22 probation. I don't know what I don't know.

23 DR. POZNANSKI: When did you get
24 involved?

25 DR. GLOVER: After she was fired, I

1 was asked to be her advisor. Up until that point,
2 my relationship with Jackie has purely been from
3 our academic and clinical interactions together,
4 with lectures, she's delivered my patients. I've
5 covered the board on labor and deliver.

6 DR. BARNEY: Just for a point of
7 clarification, I'm not sure that -- that voluntary
8 faculty are apprised of -- of a resident's
9 probation status because of concerns of
10 influencing -- I mean, unless there's --

11 DR. YAKLIC: It's a violation of --

12 DR. BARNEY: Yeah, I was going to
13 say, I don't know that that is common that people
14 know for the residents' safety in allowing them a
15 fair shake by individual evaluators.

16 DR. YAKLIC: Unless they need to
17 know.

18 DR. PAINTER: We can have one or two
19 more questions. I think we're going to have to
20 adjourn to another room, and the court reporter
21 who seems to have developed a cramped hand.

22 DR. CROOM: I just want to make one
23 point. I -- if I implied that there were no
24 consequences to you in the program, I'm in error,
25 because I appreciate what you said. I'm

1 talking -- I should have the gravity of the
2 consequences, okay?

3 DR. YAKLIC: And I would still state,
4 we've just missed an entire end of the day, and I
5 think that's pretty significant.

6 DR. CROOM: We go on with our lives.
7 The next group of residents --

8 DR. YAKLIC: Well, hopefully we do a
9 better job.

10 DR. PAINTER: Other questions or the
11 last questions?

12 DR. POZNANSKI: If you were to be
13 given another opportunity, do you think you'd be
14 ready to graduate in six months or when you're
15 supposed to graduate, and if not, what --
16 regardless, do you think you'd be ready to
17 graduate, and then what do you think you need
18 to be able to be ready to graduate in how much
19 time?

20 DR. MARES: I think I would be ready
21 to graduate. I don't believe that I lack in
22 clinical or surgical deficiencies. So more to do
23 with my personality and my attitude.

24 So I don't know what can help
25 this. Counseling has been helpful. So I guess

1 continuing with that, I'm open to suggestions, but
2 that's about all I can think of.

3 DR. PAINTER: Does anyone have any
4 other questions?

5 DR. GLOVER: I don't have any other
6 questions.

7 DR. POZNANSKI: At one point you also
8 said I was atrocious to medical students, and you
9 admitted that why?

10 DR. MARES: I think that it's been
11 made very clear I had a difficult time
12 transitioning into this program, and to terribly
13 use the whole proverb, shit runs downhill.

14 Melanie was very clear. I was
15 getting it from one end and I delivered it then to
16 my medical students that were under my charge, and
17 I know that that wasn't right and I have made
18 significant strides in that area.

19 It's not just a lack of the negative
20 comments, there have been positive comments that
21 have been shared with me, so I feel like in that
22 area, I have made significant growth.

23 I think I maybe even corrected that
24 problem.

25 DR. YAKLIC: Just one other thing. I

1 mean, Melanie made the point about when Jackie
2 came in, she was behind clinically and surgically.
3 And it was recognized, and it's something I know.

4 I interviewed her and Dr. Galloway
5 interviewed her, and we talked extensively about
6 it was a concern that she was coming to this
7 program.

8 We talked with Jackie about the fact
9 that that would be a challenge and something she
10 would have to do. Melanie suggested, well, we
11 should have done some special rotation or
12 something.

13 Our residents scrub every privacy
14 section. This was an identified problem before
15 Jackie joined. We knew it was going to be a
16 challenge. Jackie knew it was going to be a
17 challenge.

18 Again, hindsight is 20/20, but short
19 of sending her someplace else, I don't know what
20 we could have done to give her an opportunity to
21 do more surgery that wasn't taken away from
22 somebody else.

23 This situation of you had to steal
24 them from your junior residents to get more cases
25 was unavoidable. That was part of the challenge

1 of coming here.

2 We've had other residents in similar
3 situations that have come and been successful.

4 We identified that it was going to be
5 a concern moving forward. It wasn't like we
6 ignored that fact.

7 I -- again, you know, the only
8 alternative would have been not to accept Jackie
9 in the program in the first place, and I don't
10 know that that would have been fair to Jackie
11 either.

12 DR. POZNANSKI: Why did you leave the
13 other program?

14 DR. MARES: I was in a preliminary
15 position.

16 DR. YAKLIC: Well, we -- we had an
17 opening and she had a need and we -- yeah, we knew
18 there would be challenges. I'm not saying we
19 didn't, but in all honesty objectively, the only
20 alternative would have been not accept her.

21 DR. PAINTER: Going once. Going
22 twice. Where are we going before we're going to
23 get kicked out of here in --

24 DR. BARNEY: So I have a question.
25 Is the panel discussion done or is this group

1 going to be --

2 DR. PAINTER: Dismissed?

3 DR. BARNEY: -- dismissed, right.

4 DR. PAINTER: So the court reporter
5 is dismissed.

6 (Thereupon, the hearing was concluded
7 at 11:39 a.m.)

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1 STATE OF OHIO)

2 COUNTY OF MONTGOMERY) SS: CERTIFICATE

3 I, Barbara A. Nikolai, a Notary Public
4 within and for the State of Ohio, duly
5 commissioned and qualified,

6 DO HEREBY CERTIFY that the above-named
7 proceeding was reduced to writing by me
8 stenographically in the presence of the parties
9 and thereafter reduced to typewriting.

10 I FURTHER CERTIFY that I am not a relative
11 or Attorney of either party nor in any manner
12 interested in the event of this action.

13 IN WITNESS WHEREOF, I have hereunto set my
14 hand and seal of office at Dayton, Ohio, on this
15 10th day of December, 2018.

16
17 

18 BARBARA A. NIKOLAI
19 NOTARY PUBLIC, STATE OF OHIO
My commission expires 12-13-2018



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